

Mariannette J. Miller Meeks

(Original Signature of Member)

119TH CONGRESS
1ST SESSION

H. R. _____

To ensure access to affordable health insurance.

IN THE HOUSE OF REPRESENTATIVES

Mrs. MILLER-MEEKS introduced the following bill; which was referred to the
Committee on _____

A BILL

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,*

3 **SECTION 1. SHORT TITLE.**

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

6 **TITLE I—IMPROVING HEALTH**
7 **CARE OPTIONS FOR WORKERS**

8 **SEC. 101. ASSOCIATION HEALTH PLANS.**

9 (a) TREATMENT OF GROUP OR ASSOCIATION OF EM-
10 PLOYERS.—Section 3(5) of the Employee Retirement In-

1 come Security Act of 1974 (29 U.S.C. 1002(5)) is amend-
2 ed by inserting after “capacity” the following: “(including,
3 for the purpose of establishing or maintaining a group
4 health plan, a group or association of employers that satis-
5 fies the requirements of section 736(a))”.

6 (b) RULES APPLICABLE TO GROUP HEALTH PLANS
7 ESTABLISHED AND MAINTAINED BY A GROUP OR ASSO-
8 CIATION OF EMPLOYERS.—

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

13 **“SEC. 736. RULES APPLICABLE TO GROUP HEALTH PLANS**
14 **ESTABLISHED AND MAINTAINED BY A GROUP**
15 **OR ASSOCIATION OF EMPLOYERS.**

16 “(a) ASSOCIATION HEALTH PLANS.—A group or as-
17 sociation of employers may maintain a group health plan,
18 regardless of whether the employers composing such group
19 or association are in the same industry, trade, or profes-
20 sion, if such group or association satisfies the following
21 requirements:

22 “(1) GROUP OR ASSOCIATION REQUIRE-
23 MENTS.—The group or association of employers—
24 “(A) shall—

1 “(i) have been formed and maintained
2 in good faith for purposes other than pro-
3 viding health insurance coverage through a
4 group health plan;

5 “(ii) establish a governing board or
6 another indicator of formality as described
7 in paragraph (2); and

8 “(iii) have existed for at least 2 years
9 prior to offering a group health plan to the
10 employees of such group or association;
11 and

12 “(iv) make health insurance coverage
13 under the group health plan offered by
14 such group or association available—

15 “(I) to at least 51 employees;
16 and

17 “(II) to all employees of the em-
18 ployer members, and any dependents
19 of such employees;

20 “(B) may only provide health insurance
21 coverage through the group health plan of the
22 group or association—

23 “(i) to an employee of an employer
24 member of the group or association or a
25 dependent of such an employee; or

1 “(ii) as necessary to comply with part
2 6;

3 “(C) may include a health insurance issuer
4 as an employer member, except that the group
5 or association may not—

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

7 “(ii) be controlled or owned by a
8 health insurance issuer (or a subsidiary or
9 affiliate of a health insurance issuer).

10 “(D) may not condition the membership of
11 an employer in the group or association on any
12 health status-related factor (as described in sec-
13 tion 702(a)(1)) relating to any employee or de-
14 pendent of any employee of any employer mem-
15 ber.

16 “(2) ORGANIZATIONAL REQUIREMENTS.—

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

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

21 “(I) a formal organizational
22 structure with a governing board and
23 by-laws; or

24 “(II) another structure or indi-
25 cator of formality.

1 “(ii) REQUIREMENT.—Both struc-
2 tures described in subclauses (I) and (II)
3 of clause (i) shall comply with the require-
4 ments described in subparagraph (B).

5 “(B) FORMAL ORGANIZATION STRUCTURE
6 OF GROUP OR ASSOCIATION.—

7 “(i) IN GENERAL.—The functions and
8 activities of the group or association shall
9 be controlled by the employer members in
10 substance and in fact.

11 “(ii) CONTROL.—The control de-
12 scribed in clause (i) shall be satisfied so
13 long as at least 75 percent of the positions
14 on the board or other formal organiza-
15 tional structure are held by employer mem-
16 bers.

17 “(iii) ELECTIONS.—Each position of
18 the governing board or other formal orga-
19 nizational structure shall be subject to
20 scheduled elections, as determined by the
21 group or association, and each employer-
22 member shall be able to cast only one vote
23 in each such election.

24 “(C) GROUP HEALTH PLAN REQUIRE-
25 MENTS.—

1 “(i) CONTROL.—The group health
2 plan shall be controlled in substance and in
3 fact by employer members participating in
4 the group health plan.

5 “(ii) ELIGIBILITY VERIFICATION.—A
6 plan fiduciary shall verify, on a regular
7 basis and pursuant to reasonable moni-
8 toring procedures as established by the
9 plan fiduciary, whether an individual is a
10 self-employed individual if such individual
11 (or a beneficiary thereof) participates in
12 the group health plan on the basis that
13 such individual is a self-employed indi-
14 vidual.

15 “(iii) INELIGIBLE SELF-EMPLOYED
16 INDIVIDUALS.—

17 “(I) IN GENERAL.—Subject to
18 subclause (II) and except as required
19 under part 6, in the case that the
20 plan fiduciary determines that an in-
21 dividual who participates in the group
22 health plan no longer meets the re-
23 quirements under a self-employed in-
24 dividual during a plan year, the group
25 health plan shall not make health in-

1 surance coverage available to such in-
2 dividual for any plan year following
3 the plan year in which such deter-
4 mination was made.

5 “(II) REMEDIAL ACTION.—If,
6 after the plan fiduciary determines
7 that an individual described in clause
8 (i) is not a self-employed individual,
9 the individual furnishes to the plan fi-
10 duciary evidence proving that such in-
11 dividual is a self-employed individual,
12 such individual shall be eligible to par-
13 ticipate in the group health plan.

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

18 “(A) establish any rule for eligibility (in-
19 cluding continued eligibility) of any individual
20 (including an employee of an employer member
21 or a self-employed individual, or a dependent of
22 such employee or self-employed individual) to
23 enroll for benefits under the terms of the plan
24 that discriminates based on any health status-
25 related factor that relates to such individual

1 (consistent with the rules under section
2 702(a)(1));

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

15 “(C) deny coverage under such plan on the
16 basis of a pre-existing condition (consistent
17 with the rules under section 2704 of the Public
18 Health Service Act).

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

21 “(1) IN GENERAL.—A group health plan estab-
22 lished and maintained by a group or association of
23 employers that meets that requirements of this sec-
24 tion may, to the extent not prohibited under State
25 law—

1 “(A) establish base premium rates formed
2 on an actuarially sound, modified community
3 rating methodology that considers the pooling
4 of all plan participant claims; and

5 “(B) utilize the specific risk profile of each
6 employer member of such group or association
7 to determine contribution rates for each such
8 employer member’s share of a premium by ac-
9 tuarily adjusting the established base pre-
10 mium rates.

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

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

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

18 “(C) charge each plan participant the
19 same premium rate.

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

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

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

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

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

13 “(e) RULES OF CONSTRUCTION.—

14 “(1) NO EXEMPTION FROM PHSA.—Nothing in
15 this section shall be construed to exempt a group
16 health plan (as defined in section 733(a)(1)) offered
17 through a group or association of employers from
18 the requirements of this part or from the provisions
19 of part A of title XXVII of the Public Health Serv-
20 ice Act as incorporated by reference into this Act
21 through section 715.

22 “(2) PRIOR OR FUTURE GUIDANCE.—Nothing
23 in this section may be construed to limit or other-
24 wise affect the ability of a group or association of
25 employers from establishing a single plan multiple

1 employer welfare arrangement as specified in any
2 prior or future guidance issued by the Secretary of
3 Labor that provides alternative pathways to quali-
4 fying as a group or association of employer for pur-
5 poses of section 3(5).

6 “(f) DEFINITIONS.—In this section—

7 “(1) EMPLOYER MEMBER.—The term ‘employer
8 member’ means—

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

12 “(B) a group made up solely of self-em-
13 ployed individuals, within which all of the self-
14 employed individual members of such group or
15 association are aggregated together as a single
16 employer member group, provided that such
17 group includes at least 20 self-employed indi-
18 vidual members.

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

21 “(A) does not have any common law em-
22 ployees;

23 “(B) has a bona fide ownership right in a
24 trade or business, regardless of whether such

1 trade or business is incorporated or unincor-
2 porated;

3 “(C) earns a wage (as defined in section
4 3121(a) of the Internal Revenue Code of 1986)
5 or self-employment income (as defined in sec-
6 tion 1402(b) of such Code) from such trade or
7 business; and

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

11 (2) CLERICAL AMENDMENT.—The table of con-
12 tents is amended by inserting after the item relating
13 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.”.

14 **SEC. 102. CERTAIN MEDICAL STOP-LOSS INSURANCE OB-**
15 **TAINED BY CERTAIN PLAN SPONSORS OF**
16 **GROUP HEALTH PLANS NOT INCLUDED**
17 **UNDER THE DEFINITION OF HEALTH INSUR-**
18 **ANCE COVERAGE.**

19 (a) IN GENERAL.—Section 733(b)(1) of the Em-
20 ployee Retirement Income Security Act of 1974 (29
21 U.S.C. 1191b(b)(1)) is amended by adding at the end the
22 following sentence: “Such term shall not include a stop-
23 loss policy obtained by a self-insured group health plan
24 or a plan sponsor of a group health plan that self-insures

1 the health risks of its plan participants to reimburse the
2 plan or sponsor for losses that the plan or sponsor incurs
3 in providing health or medical benefits to such plan par-
4 ticipants in excess of a predetermined level set forth in
5 the stop-loss policy obtained by such plan or sponsor.”.

6 (b) EFFECT ON OTHER LAWS.—Section 514(b) of
7 the Employee Retirement Income Security Act of 1974
8 (29 U.S.C. 1144(b)) is amended by adding at the end the
9 following:

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

16 **SEC. 103. TREATMENT OF HEALTH REIMBURSEMENT AR-**
17 **RANGEMENTS INTEGRATED WITH INDIVIDUAL MARKET COVERAGE.**
18

19 (a) IN GENERAL.—

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

22 (A) by striking “EXCEPTION.—Notwith-
23 standing subsection (a)” and inserting the fol-
24 lowing: “EXCEPTIONS.—

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

3 (B) by adding at the end the following new
4 paragraph:

5 “(2) CUSTOM HEALTH OPTION AND INDIVIDUAL
6 CARE EXPENSE ARRANGEMENTS.—

7 “(A) IN GENERAL.—For purposes of this
8 subchapter, a custom health option and indi-
9 vidual care expense arrangement shall be treat-
10 ed as meeting the requirements of section 9802
11 and sections 2705, 2711, 2713, and 2715 of
12 title XXVII of the Public Health Service Act.

13 “(B) CUSTOM HEALTH OPTION AND INDI-
14 VIDUAL CARE EXPENSE ARRANGEMENTS DE-
15 FINED.—For purposes of this section, the term
16 ‘custom health option and individual care ex-
17 pense arrangement’ means a health reimburse-
18 ment arrangement—

19 “(i) which is an employer-provided
20 group health plan funded solely by em-
21 ployer contributions to provide payments
22 or reimbursements for medical care subject
23 to a maximum fixed dollar amount for a
24 period,

1 “(ii) under which such payments or
2 reimbursements may only be made for
3 medical care provided during periods dur-
4 ing which the individual is covered—

5 “(I) under individual health in-
6 surance coverage (other than coverage
7 that consists solely of excepted bene-
8 fits), or

9 “(II) under part A and B of title
10 XVIII of the Social Security Act or
11 part C of such title,

12 “(iii) which meets the nondiscrimina-
13 tion requirements of subparagraph (C),

14 “(iv) which meets the substantiation
15 requirements of subparagraph (D), and

16 “(v) which meets the notice require-
17 ments of subparagraph (E).

18 “(C) NONDISCRIMINATION.—

19 “(i) IN GENERAL.—An arrangement
20 meets the requirements of this subpara-
21 graph if an employer offering such ar-
22 rangement to an employee within a speci-
23 fied class of employee—

1 “(I) offers such arrangement to
2 all employees within such specified
3 class on the same terms, and

4 “(II) does not offer any other
5 group health plan (other than an ac-
6 count-based group health plan or a
7 group health plan that consists solely
8 of excepted benefits) to any employees
9 within such specified class.

10 In the case of an employer who offers a
11 group health plan provided through health
12 insurance coverage in the small group mar-
13 ket (that is subject to section 2701 of the
14 Public Health Service Act) to all employees
15 within such specified class, subclause (II)
16 shall not apply to such group health plan.

17 “(ii) SPECIFIED CLASS OF EM-
18 PLOYEE.—For purposes of this subpara-
19 graph, any of the following may be des-
20 ignated as a specified class of employee:

21 “(I) Full-time employees.

22 “(II) Part-time employees.

23 “(III) Salaried employees.

24 “(IV) Non-salaried employees.

1 “(V) Employees whose primary
2 site of employment is in the same rat-
3 ing area.

4 “(VI) Employees who are in-
5 cluded in a unit of employees covered
6 under a collective bargaining agree-
7 ment to which the employer is subject
8 (determined under rules similar to the
9 rules of section 105(h)).

10 “(VII) Employees who have not
11 met a group health plan, or health in-
12 surance issuer offering group health
13 insurance coverage, waiting period re-
14 quirement that satisfies section 2708
15 of the Public Health Service Act.

16 “(VIII) Seasonal employees.

17 “(IX) Employees who are non-
18 resident aliens and who receive no
19 earned income (within the meaning of
20 section 911(d)(2)) from the employer
21 which constitutes income from sources
22 within the United States (within the
23 meaning of section 861(a)(3)).

24 “(X) Under such rules as the
25 Secretary may prescribe, employees

1 who are hired for temporary place-
2 ment with an unrelated person that is
3 not the common law employer.

4 “(XI) Such other classes of em-
5 ployees as the Secretary may des-
6 ignate.

7 An employer may designate (in such man-
8 ner as is prescribed by the Secretary) two
9 or more of the classes described in the pre-
10 ceding subclauses as the specified class of
11 employees to which the arrangement is of-
12 fered for purposes of applying this sub-
13 paragraph.

14 “(iii) SPECIAL RULE FOR NEW
15 HIRES.—An employer may designate pro-
16 spectively so much of a specified class of
17 employees as are hired after a date set by
18 the employer. Such subclass of employees
19 shall be treated as the specified class for
20 purposes of applying clause (i).

21 “(iv) RULES FOR DETERMINING TYPE
22 OF EMPLOYEE.—For purposes for clause
23 (ii), any determination of full-time, part-
24 time, or seasonal employment status shall
25 be made under rules similar to the rules of

1 section 105(h) or 4980H, whichever the
2 employer elects for the plan year. Such
3 election shall apply with respect to all em-
4 ployees of the employer for the plan year.

5 “(v) PERMITTED VARIATION.—For
6 purposes of clause (i)(I), an arrangement
7 shall not fail to be treated as provided on
8 the same terms within a specified class
9 merely because the maximum dollar
10 amount of payments and reimbursements
11 which may be made under the terms of the
12 arrangement for the year with respect to
13 each employee within such class—

14 “(I) increases as additional de-
15 pendants of the employee are covered
16 under the arrangement, and

17 “(II) increases with respect to a
18 participant as the age of the partici-
19 pant increases, but not in excess of an
20 amount equal to 300 percent of the
21 lowest maximum dollar amount with
22 respect to such a participant deter-
23 mined without regard to age.

24 “(D) SUBSTANTIATION REQUIREMENTS.—

25 An arrangement meets the requirements of this

1 subparagraph if the arrangement has reason-
2 able procedures to substantiate—

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

14 “(ii) any requests made for payment
15 or reimbursement of medical care under
16 the arrangement and that the participant
17 and any dependents remain so enrolled.

18 “(E) NOTICE.—

19 “(i) IN GENERAL.—Except as pro-
20 vided in clause (iii), an arrangement meets
21 the requirements of this subparagraph if,
22 under the arrangement, each employee eli-
23 gible to participate is, not later than 60
24 days before the beginning of the plan year,
25 given written notice of the employee’s

1 rights and obligations under the arrange-
2 ment which—

3 “(I) is sufficiently accurate and
4 comprehensive to apprise the employee
5 of such rights and obligations, and

6 “(II) is written in a manner cal-
7 culated to be understood by the aver-
8 age employee eligible to participate.

9 “(ii) NOTICE REQUIREMENTS.—Such
10 notice shall include such information as the
11 Secretary may by regulation prescribe.

12 “(iii) NOTICE DEADLINE FOR CER-
13 TAIN EMPLOYEES.—In the case of an em-
14 ployee—

15 “(I) who first becomes eligible to
16 participate in the arrangement after
17 the date notice is given with respect
18 to the plan under clause (i) (deter-
19 mined without regard to this clause),
20 or

21 “(II) whose employer is first es-
22 tablished fewer than 120 days before
23 the beginning of the first plan year of
24 the arrangement,

1 the requirements of this subparagraph
2 shall be treated as met if the notice re-
3 quired under clause (i) is provided not
4 later than the date the arrangement may
5 take effect with respect to such em-
6 ployee.”.

7 (2) TREATMENT OF CURRENT RULES RELATING
8 TO CERTAIN ARRANGEMENTS.—

9 (A) NO INFERENCE.—To the extent not
10 inconsistent with the amendments made by this
11 subsection—

12 (i) no inference shall be made from
13 such amendments with respect to the rules
14 prescribed in the Federal Register on June
15 20, 2019, (84 Fed. Reg. 28888) relating to
16 health reimbursement arrangements and
17 other account-based group health plans,
18 and

19 (ii) any reference to custom health op-
20 tion and individual care expense arrange-
21 ments shall for purposes of such rules be
22 treated as including a reference to indi-
23 vidual coverage health reimbursement ar-
24 rangements.

1 (B) OTHER CONFORMING OF RULES.—The
2 Secretary of the Treasury, the Secretary of
3 Health and Human Services, and the Secretary
4 of Labor shall modify such rules as may be nec-
5 essary to conform to the amendments made by
6 this subsection.

7 (3) PARTICIPANTS IN CHOICE ARRANGEMENT
8 ELIGIBLE FOR PURCHASE OF EXCHANGE INSURANCE
9 UNDER CAFETERIA PLAN.—Section 125(f)(3) of
10 such Code is amended by adding at the end the fol-
11 lowing new subparagraph:

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

19 (4) EFFECTIVE DATE.—The amendments made
20 by this subsection shall apply to plan years begin-
21 ning after December 31, 2025.

22 (b) INCLUSION OF CHOICE ARRANGEMENT PER-
23 MITTED BENEFITS ON W-2.—

24 (1) IN GENERAL.—Section 6051(a) of such
25 Code is amended by striking “and” at the end of

1 paragraph (18), by striking the period at the end of
2 paragraph (19) and inserting “, and”, and by insert-
3 ing after paragraph (19) the following new para-
4 graph:

5 “(20) the total amount of permitted benefits for
6 enrolled individuals under a custom health option
7 and individual care expense arrangement (as defined
8 in section 9815(b)(2)) with respect to such em-
9 ployee.”.

10 (2) EFFECTIVE DATE.—The amendment made
11 by this subsection shall apply to taxable years begin-
12 ning after December 31, 2025.

13 **TITLE II—LOWERING HEALTH**
14 **CARE PREMIUMS FOR EVERY-**
15 **ONE**

16 **SEC. 201. OVERSIGHT OF PHARMACY BENEFIT MANAGE-**
17 **MENT SERVICES.**

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

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

1 **“SEC. 2799A-11. OVERSIGHT OF ENTITIES THAT PROVIDE**
2 **PHARMACY BENEFIT MANAGEMENT SERV-**
3 **ICES.**

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

15 “(1) not limit or delay the disclosure of infor-
16 mation to the group health plan (including such a
17 plan offered through a health insurance issuer) in
18 such a manner that prevents an entity providing
19 pharmacy benefit management services on behalf of
20 a group health plan or health insurance issuer offer-
21 ing group health insurance coverage from making
22 the reports described in subsection (b); and

23 “(2) provide the entity providing pharmacy ben-
24 efit management services on behalf of a group health
25 plan or health insurance issuer relevant information

1 necessary to make the reports described in sub-
2 section (b).

3 “(b) REPORTS.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after the effective date, in the case of any con-
6 tract between a group health plan or a health insur-
7 ance issuer offering group health insurance coverage
8 offered in connection with such a plan and an entity
9 providing pharmacy benefit management services on
10 behalf of such plan or issuer, including an extension
11 or renewal of such a contract, entered into on or
12 after the effective date, the entity providing phar-
13 macy benefit management services on behalf of such
14 a group health plan or health insurance issuer, not
15 less frequently than every 6 months (or, at the re-
16 quest of a group health plan, not less frequently
17 than quarterly, and under the same conditions,
18 terms, and cost of the semiannual report under this
19 subsection), shall submit to the group health plan a
20 report in accordance with this section. Each such re-
21 port shall be made available to such group health
22 plan in plain language, in a machine-readable for-
23 mat, and as the Secretary may determine, other for-
24 mats. Each such report shall include the information
25 described in paragraph (2).

1 “(2) INFORMATION DESCRIBED.—For purposes
2 of paragraph (1), the information described in this
3 paragraph is, with respect to drugs covered by a
4 group health plan or group health insurance cov-
5 erage offered by a health insurance issuer in connec-
6 tion with a group health plan during each reporting
7 period—

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

15 “(i) a list of drugs for which a claim
16 was filed and, with respect to each such
17 drug on such list—

18 “(I) the contracted compensation
19 paid by the group health plan or
20 health insurance issuer for each cov-
21 ered drug (identified by the National
22 Drug Code) to the entity providing
23 pharmacy benefit management serv-
24 ices or other applicable entity on be-

1 half of the group health plan or health
2 insurance issuer;

3 “(II) the contracted compensa-
4 tion paid to the pharmacy, by any en-
5 tity providing pharmacy benefit man-
6 agement services or other applicable
7 entity on behalf of the group health
8 plan or health insurance issuer, for
9 each covered drug (identified by the
10 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 or coverage after rebates, fees,
15 alternative discounts, or other remun-
16 eration received from applicable enti-
17 ties;

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

1 erage, or for which no claim is sub-
2 mitted under the plan or coverage;

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 or issuer from any applicable entity in
8 rebates, fees, alternative discounts, or
9 other 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 or coverage;

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 or health insurance coverage during
12 the reporting period, and, with respect to
13 each such therapeutic class—

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

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

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

1 agement services, from applicable en-
2 tities, in rebates, fees, alternative dis-
3 counts, or other remuneration from
4 such entities—

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

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

9 “(IV) the average net spending
10 per 30-day supply and per 90-day
11 supply by the plan or by the issuer
12 with respect to such coverage and its
13 participants and beneficiaries, among
14 all drugs within the therapeutic class
15 for which a claim was filed during the
16 reporting period;

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

22 “(VI) if applicable, a description
23 of the formulary tiers and utilization
24 mechanisms (such as prior authoriza-

1 tion or step therapy) employed for
2 drugs in that class; and

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

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

1 “(I) a list of all other drugs in
2 the same therapeutic class as such
3 drug;

4 “(II) if applicable, the rationale
5 for the formulary placement of such
6 drug in that therapeutic category or
7 class, selected from a list of standard
8 rationales established by the Sec-
9 retary, in consultation with stake-
10 holders; and

11 “(III) any change in formulary
12 placement compared to the prior plan
13 year; and

14 “(iv) in the case that such plan or
15 issuer (or an entity providing pharmacy
16 benefit management services on behalf of
17 such plan or issuer) has an affiliated phar-
18 macy or pharmacy under common owner-
19 ship, including mandatory mail and spe-
20 cialty home delivery programs, retail and
21 mail auto-refill programs, and cost-sharing
22 assistance incentives funded by an entity
23 providing pharmacy benefit services—

24 “(I) an explanation of any ben-
25 efit design parameters that encourage

1 or require participants and bene-
2 ficiaries in the plan or coverage to fill
3 prescriptions at mail order, specialty,
4 or retail pharmacies;

5 “(II) the percentage of total pre-
6 scriptions dispensed by such phar-
7 macies to participants or beneficiaries
8 in such plan or coverage; and

9 “(III) a list of all drugs dis-
10 pensed by such pharmacies to partici-
11 pants or beneficiaries enrolled in such
12 plan or coverage, and, with respect to
13 each drug dispensed—

14 “(aa) the amount charged,
15 per dosage unit, per 30-day sup-
16 ply, or per 90-day supply (as ap-
17 plicable) to the plan or issuer,
18 and to participants and bene-
19 ficiaries;

20 “(bb) the median amount
21 charged to such plan or issuer,
22 and the interquartile range of the
23 costs, per dosage unit, per 30-
24 day supply, and per 90-day sup-
25 ply, including amounts paid by

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

9 “(cc) the lowest cost per
10 dosage unit, per 30-day supply
11 and per 90-day supply, for each
12 such drug, including amounts
13 charged to the plan or coverage
14 and to participants and bene-
15 ficiaries, that is available from
16 any pharmacy included in the
17 network of such plan or coverage;
18 and

19 “(dd) the net acquisition
20 cost per dosage unit, per 30-day
21 supply, and per 90-day supply, if
22 such drug is subject to a max-
23 imum price discount; and

24 “(B) with respect to any group health
25 plan, including group health insurance coverage

1 offered in connection with such a plan, regard-
2 less of whether the plan or coverage is offered
3 by a specified large employer or whether it is a
4 specified large plan—

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

20 “(ii) a summary document for plans
21 and issuers to provide to participants and
22 beneficiaries, which shall be made available
23 to participants or beneficiaries upon re-
24 quest to their group health plan (including
25 in the case of group health insurance cov-

1 erage offered in connection with such a
2 plan), that—

3 “(I) contains such information
4 described in clauses (iii), (iv), (v), and
5 (vi), as applicable, as specified by the
6 Secretary through guidance, program
7 instruction, or otherwise (with no re-
8 quirement of notice and comment
9 rulemaking) that the Secretary deter-
10 mines useful to participants or bene-
11 ficiaries in better understanding the
12 plan or coverage or benefits under
13 such plan or coverage;

14 “(II) contains only aggregate in-
15 formation; and

16 “(III) states that participants
17 and beneficiaries may request specific,
18 claims-level information required to be
19 furnished under subsection (c) from
20 the group health plan or health insur-
21 ance issuer;

22 “(iii) with respect to drugs covered by
23 such plan or coverage during such report-
24 ing period—

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

3 “(II) the total amount received,
4 or expected to be received, by the plan
5 or issuer from any applicable entity in
6 rebates, fees, alternative discounts, or
7 other remuneration; and

8 “(III) to the extent feasible, in-
9 formation on the total amount of re-
10 muneration for such drugs, 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 participants
17 and beneficiaries;

18 “(iv) amounts paid directly or indi-
19 rectly in rebates, fees, or any other type of
20 compensation (as defined in section
21 408(b)(2)(B)(ii)(dd)(AA) of the Employee
22 Retirement Income Security Act) to bro-
23 kerage firms, brokers, consultants, advi-
24 sors, or any other individual or firm, for—

1 “(I) the referral of the group
2 health plan’s or health insurance
3 issuer’s business to an entity pro-
4 viding pharmacy benefit management
5 services, including the identity of the
6 recipient of such amounts;

7 “(II) consideration of the entity
8 providing pharmacy benefit manage-
9 ment services by the group health
10 plan or health insurance issuer; or

11 “(III) the retention of the entity
12 by the group health plan or health in-
13 surance issuer;

14 “(v) an explanation of any benefit de-
15 sign parameters that encourage or require
16 participants and beneficiaries in such plan
17 or coverage to fill prescriptions at mail
18 order, specialty, or retail pharmacies that
19 are affiliated with or under common own-
20 ership with the entity providing pharmacy
21 benefit management services under such
22 plan or coverage, including mandatory mail
23 and specialty home delivery programs, re-
24 tail and mail auto-refill programs, and

1 cost-sharing assistance incentives directly
2 or indirectly funded by such entity; and
3 “(vi) total gross spending on all drugs
4 under the plan or coverage during the re-
5 porting period.

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

21 “(4) PRIVACY REQUIREMENTS.—

22 “(A) IN GENERAL.—An entity providing
23 pharmacy benefit management services on be-
24 half of a group health plan or a health insur-
25 ance issuer offering group health insurance cov-

1 erage shall report information under paragraph
2 (1) in a manner consistent with the privacy reg-
3 ulations promulgated under section 13402(a) of
4 the Health Information Technology for Eco-
5 nomic and Clinical Health Act and consistent
6 with the privacy regulations promulgated under
7 the Health Insurance Portability and Account-
8 ability Act of 1996 in part 160 and subparts A
9 and E of part 164 of title 45, Code of Federal
10 Regulations (or successor regulations) (referred
11 to in this paragraph as the ‘HIPAA privacy
12 regulations’) and shall restrict the use and dis-
13 closure of such information according to such
14 privacy regulations and such HIPAA privacy
15 regulations.

16 “(B) ADDITIONAL REQUIREMENTS.—

17 “(i) IN GENERAL.—An entity pro-
18 viding pharmacy benefit management serv-
19 ices on behalf of a group health plan or
20 health insurance issuer offering group
21 health insurance coverage that submits a
22 report under paragraph (1) shall ensure
23 that such report contains only summary
24 health information, as defined in section

1 164.504(a) of title 45, Code of Federal
2 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, including with respect to
9 group health insurance coverage offered in con-
10 nection with a group health plan, shall provide
11 to each participant or beneficiary written notice
12 informing the participant or beneficiary of the
13 requirement for entities providing pharmacy
14 benefit management services on behalf of the
15 group health plan or health insurance issuer of-
16 fering group health insurance coverage to sub-
17 mit reports to group health plans under para-
18 graph (1), as applicable, which may include in-
19 corporating such notification in plan documents
20 provided to the participant or beneficiary, or
21 providing individual notification.

22 “(E) LIMITATION TO BUSINESS ASSOCI-
23 ATES.—A group health plan receiving a report
24 under paragraph (1) may disclose such informa-
25 tion only to the entity from which the report

1 was received or to that entity's business associ-
2 ates as defined in section 160.103 of title 45,
3 Code of Federal Regulations (or successor regu-
4 lations) or as permitted by the HIPAA privacy
5 regulations.

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

16 “(i) restrict disclosure of such report
17 to the Department of Health and Human
18 Services, the Department of Labor, or the
19 Department of the Treasury; or

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

23 “(G) LIMITED FORM OF REPORT.—The
24 Secretary shall define through rulemaking a
25 limited form of the report under paragraph (1)

1 required with respect to any group health plan
2 established by a plan sponsor that is, or is af-
3 filiated with, a drug manufacturer, drug whole-
4 saler, or other direct participant in the drug
5 supply chain, in order to prevent anti-competi-
6 tive behavior.

7 “(5) STANDARD FORMAT AND REGULATIONS.—

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

17 “(B) ADDITIONAL REGULATIONS.—Not
18 later than 18 months after the date of enact-
19 ment of this section, the Secretary shall,
20 through rulemaking, promulgate any other final
21 regulations necessary to implement the require-
22 ments of this section. In promulgating such
23 regulations, the Secretary shall, to the extent
24 practicable, align the reporting requirements

1 under this section with the reporting require-
2 ments under section 2799A–10.

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

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

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

14 “(d) ENFORCEMENT.—

15 “(1) IN GENERAL.—The Secretary shall enforce
16 this section. The enforcement authority under this
17 subsection shall apply only with respect to group
18 health plans (including group health insurance cov-
19 erage offered in connection with such a plan) to
20 which the requirements of subparts I and II of part
21 A and part D apply in accordance with section 2722,
22 and with respect to entities providing pharmacy ben-
23 efit management services on behalf of such plans
24 and applicable entities providing services on behalf
25 of such plans.

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

16 “(3) FALSE INFORMATION.—A health insurance
17 issuer, an entity providing pharmacy benefit man-
18 agement services, or a third party administrator pro-
19 viding services on behalf of such issuer offered by a
20 health insurance issuer that knowingly provides false
21 information under this section shall be subject to a
22 civil monetary penalty in an amount not to exceed
23 \$100,000 for each item of false information. Such
24 civil monetary penalty shall be in addition to other
25 penalties as may be prescribed by law.

1 “(4) PROCEDURE.—The provisions of section
2 1128A of the Social Security Act, other than sub-
3 sections (a) and (b) and the first sentence of sub-
4 section (c)(1) of such section shall apply to civil
5 monetary penalties under this subsection in the
6 same manner as such provisions apply to a penalty
7 or proceeding under such section.

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

14 “(e) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion shall be construed to permit a health insurance issuer,
16 group health plan, entity providing pharmacy benefit man-
17 agement services on behalf of a group health plan or
18 health insurance issuer, or other entity to restrict disclo-
19 sure to, or otherwise limit the access of, the Secretary to
20 a report described in subsection (b)(1) or information re-
21 lated to compliance with subsections (a), (b), (c), or (d)
22 by such issuer, plan, or entity.

23 “(f) DEFINITIONS.—In this section:

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

1 “(A) an applicable group purchasing orga-
2 nization, drug manufacturer, distributor, whole-
3 saler, rebate aggregator (or other purchasing
4 entity designed to aggregate rebates), or associ-
5 ated third party;

6 “(B) any subsidiary, parent, affiliate, or
7 subcontractor of a group health plan, health in-
8 surance issuer, entity that provides pharmacy
9 benefit management services on behalf of such
10 a plan or issuer, or any entity described in sub-
11 paragraph (A); or

12 “(C) such other entity as the Secretary
13 may specify through rulemaking.

14 “(2) APPLICABLE GROUP PURCHASING ORGANI-
15 ZATION.—The term ‘applicable group purchasing or-
16 ganization’ means a group purchasing organization
17 that is affiliated with or under common ownership
18 with an entity providing pharmacy benefit manage-
19 ment services.

20 “(3) CONTRACTED COMPENSATION.—The term
21 ‘contracted compensation’ means the sum of any in-
22 gredient cost and dispensing fee for a drug (inclusive
23 of the out-of-pocket costs to the participant or bene-
24 ficiary), or another analogous compensation struc-

1 ture that the Secretary may specify through regula-
2 tions.

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

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

17 “(6) PLAN SPONSOR.—The term ‘plan sponsor’
18 has the meaning given such term in section 3(16)(B)
19 of the Employee Retirement Income Security Act of
20 1974.

21 “(7) REMUNERATION.—The term ‘remunera-
22 tion’ has the meaning given such term by the Sec-
23 retary through rulemaking, which shall be reeval-
24 ated by the Secretary every 5 years.

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

12 “(9) SPECIFIED LARGE PLAN.—The term ‘spec-
13 ified large plan’ means a group health plan (includ-
14 ing group health insurance coverage offered in con-
15 nection with such a plan) established or maintained
16 by a plan sponsor described in clause (ii) or (iii) of
17 section 3(16)(B) of the Employee Retirement In-
18 come Security Act of 1974 that had an average of
19 at least 100 participants on business days during
20 the preceding calendar year or plan year, as applica-
21 ble.

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

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

2 (A) in subsection (a)—

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

6 (ii) in paragraph (2), by inserting
7 “(other than section 2799A-11)” after
8 “part D”; and

9 (B) in subsection (b)—

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

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

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

19 (b) EMPLOYEE RETIREMENT INCOME SECURITY ACT
20 OF 1974.—

21 (1) IN GENERAL.—Subtitle B of title I of the
22 Employee Retirement Income Security Act of 1974
23 (29 U.S.C. 1021 et seq.) is amended—

1 (A) in subpart B of part 7 (29 U.S.C.
2 1185 et seq.), by adding at the end the fol-
3 lowing:

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

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

17 “(1) not limit or delay the disclosure of infor-
18 mation to the group health plan (including such a
19 plan offered through a health insurance issuer) in
20 such a manner that prevents an entity providing
21 pharmacy benefit management services on behalf of
22 a group health plan or health insurance issuer offer-
23 ing group health insurance coverage from making
24 the reports described in subsection (b); and

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

6 “(b) REPORTS.—

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

1 mat, and as the Secretary may determine, other for-
2 mats. Each such report shall include the information
3 described in paragraph (2).

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

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

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

21 “(I) the contracted compensation
22 paid by the group health plan or
23 health insurance issuer for each cov-
24 ered drug (identified by the National
25 Drug Code) to the entity providing

1 pharmacy benefit management serv-
2 ices or other applicable entity on be-
3 half of the group health plan or health
4 insurance issuer;

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

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

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

20 “(V) for each claim for the drug
21 (including original prescriptions and
22 refills) and for each dosage unit of the
23 drug for which a claim was filed, the
24 type of dispensing channel used to

1 furnish the drug, including retail, mail
2 order, or specialty pharmacy;

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

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

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

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

24 “(bb) the total number of—

1 “(AA) prescription
2 claims (including original
3 prescriptions and refills);

4 “(BB) participants and
5 beneficiaries for whom a
6 claim for such drug was
7 filed through the applicable
8 dispensing channel;

9 “(CC) dosage units and
10 dosage units per fill of such
11 drug; and

12 “(DD) days supply of
13 such drug per fill;

14 “(VII) the net price per course of
15 treatment or single fill, such as a 30-
16 day supply or 90-day supply to the
17 plan or coverage after rebates, fees,
18 alternative discounts, or other remun-
19 eration received from applicable enti-
20 ties;

21 “(VIII) the total amount of out-
22 of-pocket spending by participants
23 and beneficiaries on such drug, in-
24 cluding spending through copayments,
25 coinsurance, and deductibles, but not

1 including any amounts spent by par-
2 ticipants and beneficiaries on drugs
3 not covered under the plan or cov-
4 erage, or for which no claim is sub-
5 mitted under the plan or coverage;

6 “(IX) the total net spending on
7 the drug;

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

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

20 “(aa) for claims incurred
21 during the reporting period; and

22 “(bb) that is related to utili-
23 zation of such drug or spending
24 on such drug; and

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

12 “(ii) a list of each therapeutic class
13 (as defined by the Secretary) for which a
14 claim was filed under the group health
15 plan or health insurance coverage during
16 the reporting period, and, with respect to
17 each such therapeutic class—

18 “(I) the total gross spending on
19 drugs in such class before rebates,
20 price concessions, alternative dis-
21 counts, or other remuneration from
22 applicable entities;

23 “(II) the net spending in such
24 class after such rebates, price conces-

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

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

10 “(aa) for claims incurred
11 during the reporting period; and

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

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

22 “(V) the number of participants
23 and beneficiaries who filled a prescrip-
24 tion for a drug in such class, includ-

1 ing the National Drug Code for each
2 such drug;

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

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

18 “(iii) with respect to any drug for
19 which gross spending under the group
20 health plan or health insurance coverage
21 exceeded \$10,000 during the reporting pe-
22 riod or, in the case that gross spending
23 under the group health plan or coverage
24 exceeded \$10,000 during the reporting pe-
25 riod with respect to fewer than 50 drugs,

1 with respect to the 50 prescription drugs
2 with the highest spending during the re-
3 porting period—

4 “(I) a list of all other drugs in
5 the same therapeutic class as such
6 drug;

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

14 “(III) any change in formulary
15 placement compared to the prior plan
16 year; and

17 “(iv) in the case that such plan or
18 issuer (or an entity providing pharmacy
19 benefit management services on behalf of
20 such plan or issuer) has an affiliated phar-
21 macy or pharmacy under common owner-
22 ship, including mandatory mail and spe-
23 cialty home delivery programs, retail and
24 mail auto-refill programs, and cost sharing

1 assistance incentives funded by an entity
2 providing pharmacy benefit services—

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

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

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

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

24 “(bb) the median amount
25 charged to such plan or issuer,

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

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

23 “(dd) the net acquisition
24 cost per dosage unit, per 30-day
25 supply, and per 90-day supply, if

1 such drug is subject to a max-
2 imum price discount; and

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

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

24 “(ii) a summary document for plans
25 and issuers to provide to participants and

1 beneficiaries, which shall be made available
2 to participants or beneficiaries upon re-
3 quest to their group health plan (including
4 in the case of group health insurance cov-
5 erage offered in connection with such a
6 plan), that—

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

18 “(II) contains only aggregate in-
19 formation; and

20 “(III) states that participants
21 and beneficiaries may request specific,
22 claims-level information required to be
23 furnished under subsection (c) from
24 the group health plan or health insur-
25 ance issuer;

1 “(iii) with respect to drugs covered by
2 such plan or coverage during such report-
3 ing period—

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

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

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

21 “(iv) amounts paid directly or indi-
22 rectly in rebates, fees, or any other type of
23 compensation (as defined in section
24 408(b)(2)(B)(ii)(dd)(AA)) to brokerage

1 firms, brokers, consultants, advisors, or
2 any other individual or firm, for—

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

9 “(II) consideration of the entity
10 providing pharmacy benefit manage-
11 ment services by the group health
12 plan or health insurance issuer; or

13 “(III) the retention of the entity
14 by the group health plan or health in-
15 surance issuer;

16 “(v) an explanation of any benefit de-
17 sign parameters that encourage or require
18 participants and beneficiaries in such plan
19 or coverage to fill prescriptions at mail
20 order, specialty, or retail pharmacies that
21 are affiliated with or under common own-
22 ership with the entity providing pharmacy
23 benefit management services under such
24 plan or coverage, including mandatory mail
25 and specialty home delivery programs, re-

1 tail and mail auto-refill programs, and
2 cost-sharing assistance incentives directly
3 or indirectly funded by such entity; and

4 “(vi) total gross spending on all drugs
5 under the plan or coverage during the re-
6 porting period.

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

22 “(4) PRIVACY REQUIREMENTS.—

23 “(A) IN GENERAL.—An entity providing
24 pharmacy benefit management services on be-
25 half of a group health plan or a health insur-

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

17 “(B) ADDITIONAL REQUIREMENTS.—

18 “(i) IN GENERAL.—An entity pro-
19 viding pharmacy benefit management serv-
20 ices on behalf of a group health plan or
21 health insurance issuer offering group
22 health insurance coverage that submits a
23 report under paragraph (1) shall ensure
24 that such report contains only summary
25 health information, as defined in section

1 164.504(a) of title 45, Code of Federal
2 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, including with respect to
9 group health insurance coverage offered in con-
10 nection with a group health plan, shall provide
11 to each participant or beneficiary written notice
12 informing the participant or beneficiary of the
13 requirement for entities providing pharmacy
14 benefit management services on behalf of the
15 group health plan or health insurance issuer of-
16 fering group health insurance coverage to sub-
17 mit reports to group health plans under para-
18 graph (1), as applicable, which may include in-
19 corporating such notification in plan documents
20 provided to the participant or beneficiary, or
21 providing individual notification.

22 “(E) LIMITATION TO BUSINESS ASSOCI-
23 ATES.—A group health plan receiving a report
24 under paragraph (1) may disclose such informa-
25 tion only to the entity from which the report

1 was received or to that entity's business associ-
2 ates as defined in section 160.103 of title 45,
3 Code of Federal Regulations (or successor regu-
4 lations) or as permitted by the HIPAA privacy
5 regulations.

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

16 “(i) restrict disclosure of such report
17 to the Department of Health and Human
18 Services, the Department of Labor, or the
19 Department of the Treasury; or

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

23 “(G) LIMITED FORM OF REPORT.—The
24 Secretary shall define through rulemaking a
25 limited form of the report under paragraph (1)

1 required with respect to any group health plan
2 established by a plan sponsor that is, or is af-
3 filiated with, a drug manufacturer, drug whole-
4 saler, or other direct participant in the drug
5 supply chain, in order to prevent anti-competi-
6 tive behavior.

7 “(5) STANDARD FORMAT AND REGULATIONS.—

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

17 “(B) ADDITIONAL REGULATIONS.—Not
18 later than 18 months after the date of enact-
19 ment of this section, the Secretary shall,
20 through rulemaking, promulgate any other final
21 regulations necessary to implement the require-
22 ments of this section. In promulgating such
23 regulations, the Secretary shall, to the extent
24 practicable, align the reporting requirements

1 under this section with the reporting require-
2 ments under section 725.

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

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

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

14 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion shall be construed to permit a health insurance issuer,
16 group health plan, entity providing pharmacy benefit man-
17 agement services on behalf of a group health plan or
18 health insurance issuer, or other entity to restrict dislo-
19 sure to, or otherwise limit the access of, the Secretary to
20 a report described in subsection (b)(1) or information re-
21 lated to compliance with subsections (a), (b), or (c) of this
22 section or section 502(c)(13) by such issuer, plan, or enti-
23 ty.

24 “(e) DEFINITIONS.—In this section:

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

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

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

14 “(C) such other entity as the Secretary
15 may specify through rulemaking.

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

22 “(3) CONTRACTED COMPENSATION.—The term
23 ‘contracted compensation’ means the sum of any in-
24 gredient cost and dispensing fee for a drug (inclusive
25 of the out-of-pocket costs to the participant or bene-

1 ficiary), or another analogous compensation struc-
2 ture that the Secretary may specify through regula-
3 tions.

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

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

18 “(6) PLAN SPONSOR.—The term ‘plan sponsor’
19 has the meaning given such term in section
20 3(16)(B).

21 “(7) REMUNERATION.—The term ‘remunera-
22 tion’ has the meaning given such term by the Sec-
23 retary through rulemaking, which shall be reeval-
24 ated by the Secretary every 5 years.

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

12 “(9) SPECIFIED LARGE PLAN.—The term ‘spec-
13 ified large plan’ means a group health plan (includ-
14 ing group health insurance coverage offered in con-
15 nection with such a plan) established or maintained
16 by a plan sponsor described in clause (ii) or (iii) of
17 section 3(16)(B) that had an average of at least 100
18 participants on business days during the preceding
19 calendar year or plan year, as applicable.

20 “(10) WHOLESALE ACQUISITION COST.—The
21 term ‘wholesale acquisition cost’ has the meaning
22 given such term in section 1847A(c)(6)(B) of the
23 Social Security Act (42 U.S.C. 1395w-
24 3a(c)(6)(B)).”;

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

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

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

7 (iii) in subsection (c), by adding at
8 the end the following:

9 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
10 RELATING TO OVERSIGHT OF PHARMACY BENEFIT
11 MANAGEMENT SERVICES.—

12 “(A) FAILURE TO PROVIDE INFORMA-
13 TION.—The Secretary may impose a penalty
14 against a plan administrator of a group health
15 plan, a health insurance issuer offering group
16 health insurance coverage, or an entity pro-
17 viding pharmacy benefit management services
18 on behalf of such a plan or issuer, or an appli-
19 cable entity (as defined in section 726(f)) that
20 violates section 726(a); an entity providing
21 pharmacy benefit management services on be-
22 half of such a plan or issuer that fails to pro-
23 vide the information required under section
24 726(b); or any person who causes a group
25 health plan to fail to provide the information

1 required under section 726(c), in the amount of
2 \$10,000 for each day during which such viola-
3 tion continues or such information is not dis-
4 closed or reported.

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

17 “(C) WAIVERS.—The Secretary may waive
18 penalties under subparagraph (A), or extend
19 the period of time for compliance with a re-
20 quirement of this section, for an entity in viola-
21 tion of section 726 that has made a good-faith
22 effort to comply with the requirements of sec-
23 tion 726.”; and

1 (C) in section 732(a) (29 U.S.C.
2 1191a(a)), by striking “section 711” and in-
3 serting “sections 711 and 726”.

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

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

9 (c) INTERNAL REVENUE CODE OF 1986.—

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

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

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

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

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

11 “(b) REPORTS.—

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

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

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

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

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

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

1 services or other applicable entity on
2 behalf of the group health plan;

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

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

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

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

24 “(VI) with respect to each drug
25 dispensed, for each type of dispensing

1 channel (including retail, mail order,
2 or specialty pharmacy)—

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

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

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

20 “(bb) the total number of—

21 “(AA) prescription
22 claims (including original
23 prescriptions and refills);

24 “(BB) participants and
25 beneficiaries for whom a

1 claim for such drug was
2 filed through the applicable
3 dispensing channel;

4 “(CC) dosage units and
5 dosage units per fill of such
6 drug; and

7 “(DD) days supply of
8 such drug per fill;

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

15 “(VIII) the total amount of out-
16 of-pocket spending by participants
17 and beneficiaries on such drug, in-
18 cluding spending through copayments,
19 coinsurance, and deductibles, but not
20 including any amounts spent by par-
21 ticipants and beneficiaries on drugs
22 not covered under the plan, or for
23 which no claim is submitted under the
24 plan;

1 “(IX) the total net spending on
2 the drug;

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

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

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

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

20 “(XII) to the extent feasible, in-
21 formation on the total amount of re-
22 muneration for such drug, including
23 copayment assistance dollars paid, co-
24 payment cards applied, or other dis-
25 counts provided by each drug manu-

1 facturer (or entity administering co-
2 payment assistance on behalf of such
3 drug manufacturer), to the partici-
4 pants and beneficiaries enrolled in
5 such plan;

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

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

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

20 “(III) the total amount received,
21 or expected to be received, by the enti-
22 ty providing pharmacy benefit man-
23 agement services, from applicable en-
24 tities, in rebates, fees, alternative dis-

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 drugs or drug spending;

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

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

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

24 “(VII) the total out-of-pocket
25 spending under the plan by partici-

1 pants and beneficiaries, including
2 spending through copayments, coin-
3 surance, and deductibles, but not in-
4 cluding any amounts spent by partici-
5 pants and beneficiaries on drugs not
6 covered under the plan or for which
7 no claim is submitted under the plan;
8 “(iii) with respect to any drug for
9 which gross spending under the group
10 health plan exceeded \$10,000 during the
11 reporting period or, in the case that gross
12 spending under the group health plan ex-
13 ceeded \$10,000 during the reporting pe-
14 riod with respect to fewer than 50 drugs,
15 with respect to the 50 prescription drugs
16 with the highest spending during the re-
17 porting period—
18 “(I) a list of all other drugs in
19 the same therapeutic class as such
20 drug;
21 “(II) if applicable, the rationale
22 for the formulary placement of such
23 drug in that therapeutic category or
24 class, selected from a list of standard
25 rationales established by the Sec-

1 retary, in consultation with stake-
2 holders; and

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

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

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

22 “(II) the percentage of total pre-
23 scriptions dispensed by such phar-
24 macies to participants or beneficiaries
25 in such plan; and

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

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

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

24 “(cc) the lowest cost per
25 dosage unit, per 30-day supply

1 and per 90-day supply, for each
2 such drug, including amounts
3 charged to the plan and to par-
4 ticipants and beneficiaries, that
5 is available from any pharmacy
6 included in the network of such
7 plan; and

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

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

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

1 ing pharmacy benefit management serv-
2 ices, such as an estimated net price to
3 group health plan and participant or bene-
4 ficiary, a cost per claim, the fee structure
5 or reimbursement model, and estimated
6 cost per participant or beneficiary;

7 “(ii) a summary document for plans
8 to provide to participants and beneficiaries,
9 which shall be made available to partici-
10 pants or beneficiaries upon request to their
11 group health 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 benefits under such plan;

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;

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

6 “(I) the total net spending by the
7 plan for all such drugs;

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

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

23 “(iv) amounts paid directly or indi-
24 rectly in rebates, fees, or any other type of
25 compensation (as defined in section

1 408(b)(2)(B)(ii)(dd)(AA) of the Employee
2 Retirement Income Security Act (29
3 U.S.C. 1108(b)(2)(B)(ii)(dd)(AA))) to bro-
4 kerage firms, brokers, consultants, advi-
5 sors, or any other individual or firm, for—

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

11 “(II) consideration of the entity
12 providing pharmacy benefit manage-
13 ment services by the group health
14 plan; or

15 “(III) the retention of the entity
16 by the group health plan;

17 “(v) an explanation of any benefit de-
18 sign parameters that encourage or require
19 participants and beneficiaries in such plan
20 to fill prescriptions at mail order, specialty,
21 or retail pharmacies that are affiliated with
22 or under common ownership with the enti-
23 ty providing pharmacy benefit management
24 services under such plan, including manda-
25 tory mail and specialty home delivery pro-

1 grams, retail and mail auto-refill pro-
2 grams, and cost-sharing assistance incen-
3 tives directly or indirectly funded by such
4 entity; and

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

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

22 “(4) PRIVACY REQUIREMENTS.—

23 “(A) IN GENERAL.—An entity providing
24 pharmacy benefit management services on be-
25 half of a group health plan shall report infor-

1 mation under paragraph (1) in a manner con-
2 sistent with the privacy regulations promul-
3 gated under section 13402(a) of the Health In-
4 formation Technology for Economic and Clin-
5 ical Health Act (42 U.S.C. 17932(a)) and con-
6 sistent with the privacy regulations promul-
7 gated under the Health Insurance Portability
8 and Accountability Act of 1996 in part 160 and
9 subparts A and E of part 164 of title 45, Code
10 of Federal Regulations (or successor regula-
11 tions) (referred to in this paragraph as the
12 ‘HIPAA privacy regulations’) and shall restrict
13 the use and disclosure of such information ac-
14 cording to such privacy regulations and such
15 HIPAA privacy regulations.

16 “(B) ADDITIONAL REQUIREMENTS.—

17 “(i) IN GENERAL.—An entity pro-
18 viding pharmacy benefit management serv-
19 ices on behalf of a group health plan that
20 submits a report under paragraph (1) shall
21 ensure that such report contains only sum-
22 mary health information, as defined in sec-
23 tion 164.504(a) of title 45, Code of Fed-
24 eral Regulations (or successor regulations).

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

8 “(C) RULE OF CONSTRUCTION.—

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

14 “(ii) Nothing in this section shall be
15 construed to affect the application of any
16 Federal or State privacy or civil rights law,
17 including the HIPAA privacy regulations,
18 the Genetic Information Nondiscrimination
19 Act of 2008 (Public Law 110–233) (in-
20 cluding the amendments made by such
21 Act), the Americans with Disabilities Act
22 of 1990 (42 U.S.C. 12101 et seq.), section
23 504 of the Rehabilitation Act of 1973 (29
24 U.S.C. 794), section 1557 of the Patient
25 Protection and Affordable Care Act (42

1 U.S.C. 18116), title VI of the Civil Rights
2 Act of 1964 (42 U.S.C. 2000d), and title
3 VII of the Civil Rights Act of 1964 (42
4 U.S.C. 2000e).

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

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

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

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

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

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

1 “(5) STANDARD FORMAT AND REGULATIONS.—

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

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

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

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

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

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

13 “(e) DEFINITIONS.—In this section:

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

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

21 “(B) any subsidiary, parent, affiliate, or
22 subcontractor of a group health plan, health in-
23 surance issuer, entity that provides pharmacy
24 benefit management services on behalf of such

1 a plan or issuer, or any entity described in sub-
2 paragraph (A); or

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

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

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

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

24 “(5) NET SPENDING.—The term ‘net spending’,
25 with respect to prescription drug benefits under a

1 group health plan, means the amount spent by a
2 group health plan on prescription drug benefits, cal-
3 culated after the application of rebates, fees, alter-
4 native discounts, or other remuneration.

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

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

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

22 “(9) SPECIFIED LARGE PLAN.—The term ‘spec-
23 ified large plan’ means a group health plan estab-
24 lished or maintained by a plan sponsor described in
25 clause (ii) or (iii) of section 3(16)(B) of the Em-

1 ployee Retirement Income Security Act of 1974 (29
2 U.S.C. 1002(16)(B)) that had an average of at least
3 100 participants on business days during the pre-
4 ceding calendar year or plan year, as applicable.

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

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

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

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

1 (e)(1) to the employer) shall be treated as including a ref-
2 erence to such entity.”.

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

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

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

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

11 “(h) FUNDING.—

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

17 “(2) LIMITATION.—

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