

119TH CONGRESS
1ST SESSION

H. R. 6703

AN ACT

To ensure access to affordable health insurance.

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

1 **SECTION 1. SHORT TITLE.**

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

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

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

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

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

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

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

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

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

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

6 “(A) shall—

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

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

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

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

21 “(I) to at least 51 employees;

22 and

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

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

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

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

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

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

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

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

22 “(2) ORGANIZATIONAL REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 “(e) RULES OF CONSTRUCTION.—

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

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

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

14 “(f) DEFINITIONS.—In this section—

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

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

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

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

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

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

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

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

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

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

“735. Standardized reporting format.

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

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

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

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

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

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

4 (a) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 “(C) NONDISCRIMINATION.—

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

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

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

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

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

graph, any of the following may be designated as a specified class of employee:

“(I) Full-time employees.

“(II) Part-time employees.

“(III) Salaried employees.

“(IV) Non-salaried employees.

“(V) Employees whose primary site of employment is in the same rating area.

“(VI) Employees who are included in a unit of employees covered under a collective bargaining agreement to which the employer is subject (determined under rules similar to the rules of section 105(h)).

“(VII) Employees who have not met a group health plan, or health insurance issuer offering group health insurance coverage, waiting period requirement that satisfies section 2708 of the Public Health Service Act.

“(VIII) Seasonal employees.

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

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

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

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

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

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

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

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

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

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

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

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

6 “(D) SUBSTANTIATION REQUIREMENTS.—

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

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

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

25 “(E) NOTICE.—

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

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

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

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

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

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

1 mined without regard to this clause),
2 or
3 “(II) whose employer is first es-
4 tablished fewer than 120 days before
5 the beginning of the first plan year of
6 the arrangement,
7 the requirements of this subparagraph
8 shall be treated as met if the notice re-
9 quired under clause (i) is provided not
10 later than the date the arrangement may
11 take effect with respect to such em-
12 ployee.”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(b) REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 “(IX) the total net spending on
12 the drug;
13

14 “(X) the total amount received,
15 or expected to be received, by the plan
16 or issuer from any applicable entity in
17 rebates, fees, alternative discounts, or
18 other remuneration;
19
20

21 “(XI) the total amount received,
22 or expected to be received, by the entity providing pharmacy benefit management services, from applicable entities, in rebates, fees, alternative discounts,
23
24
25

1 counts, or other remuneration from
2 such entities—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 network of such plan or coverage;
2 and

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

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

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

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

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

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

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

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

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

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

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

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

1 drug manufacturer) to participants
2 and beneficiaries;

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

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

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

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

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

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

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

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

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

4 “(4) PRIVACY REQUIREMENTS.—

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

24 “(B) ADDITIONAL REQUIREMENTS.—

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

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

18 “(C) RULE OF CONSTRUCTION.—

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

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

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

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

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

“(E) LIMITATION TO BUSINESS ASSOCIATES.—A group health plan receiving a report under paragraph (1) may disclose such information only to the entity from which the report was received or to that entity’s business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations) or as permitted by the HIPAA privacy regulations.

“(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent an entity providing pharmacy benefit management services on behalf of a group health plan or health insurance issuer offering group health insurance coverage, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan, issuer, or entity may not—

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

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

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

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

15 “(5) STANDARD FORMAT AND REGULATIONS.—

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

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

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

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

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

22 “(d) ENFORCEMENT.—

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

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

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

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

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

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

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

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

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

6 “(f) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (A) in subsection (a)—

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

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

15 (B) in subsection (b)—

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

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

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

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

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

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

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

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

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

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

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

10 “(b) REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 cost per dosage unit, on the
2 date such drug was dis-
3 pensed; and

4 “(bb) the total number of—
5 “(AA) prescription
6 claims (including original
7 prescriptions and refills);

8 “(BB) participants and
9 beneficiaries for whom a
10 claim for such drug was
11 filed through the applicable
12 dispensing channel;

13 “(CC) dosage units and
14 dosage units per fill of such
15 drug; and

16 “(DD) days supply of
17 such drug per fill;

18 “(VII) the net price per course of
19 treatment or single fill, such as a 30-
20 day supply or 90-day supply to the
21 plan or coverage after rebates, fees,
22 alternative discounts, or other remu-
23 nation received from applicable enti-
24 ties;

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

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

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

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

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

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

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

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

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

1 counts, or other remuneration from
2 applicable entities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ership with the entity providing pharmacy benefit management services under such plan or coverage, including mandatory mail and specialty home delivery programs, retail and mail auto-refill programs, and cost-sharing assistance incentives directly or indirectly funded by such entity; and

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

“(3) OPT-IN FOR GROUP HEALTH INSURANCE COVERAGE OFFERED BY A SPECIFIED LARGE EMPLOYER OR THAT IS A SPECIFIED LARGE PLAN.—In the case of group health insurance coverage offered in connection with a group health plan that is offered by a specified large employer or is a specified large plan, such group health plan may, on an annual basis, for plan years beginning on or after the date that is 30 months after the date of enactment of this section, elect to require an entity providing pharmacy benefit management services on behalf of the health insurance issuer to submit to such group health plan a report that includes all of the information described in paragraph (2)(A), in addition to the information described in paragraph (2)(B).

1 “(4) PRIVACY REQUIREMENTS.—

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

21 “(B) ADDITIONAL REQUIREMENTS.—

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

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

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

14 “(C) RULE OF CONSTRUCTION.—

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

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

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

“(D) WRITTEN NOTICE.—Each plan year, group health plans, including with respect to group health insurance coverage offered in connection with a group health plan, shall provide to each participant or beneficiary written notice informing the participant or beneficiary of the requirement for entities providing pharmacy benefit management services on behalf of the group health plan or health insurance issuer offering group health insurance coverage to submit reports to group health plans under paragraph (1), as applicable, which may include incorporating such notification in plan documents provided to the participant or beneficiary, or providing individual notification.

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

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

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

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

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

13 “(5) STANDARD FORMAT AND REGULATIONS.—

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

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

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

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

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

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

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

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

4 “(e) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) in section 502 (29 U.S.C. 1132)—

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

(ii) in subsection (b)(3), by striking “under subsection (c)(9)” and inserting “under paragraphs (9) and (13) of subsection (c)”;

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

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

“(A) FAILURE TO PROVIDE INFORMATION.—The Secretary may impose a penalty against a plan administrator of a group health plan, a health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefit management services on behalf of such a plan or issuer, or an applicable entity (as defined in section 726(f)) that violates section 726(a); an entity providing pharmacy benefit management services on be-

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

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

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

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

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

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

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

11 (c) INTERNAL REVENUE CODE OF 1986.—

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

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

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

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

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

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

13 “(b) REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 which no claim is submitted under the
2 plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 “(4) PRIVACY REQUIREMENTS.—

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

19 “(B) ADDITIONAL REQUIREMENTS.—

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

tion 164.504(a) of title 45, Code of Federal Regulations (or successor regulations).

“(ii) RESTRICTIONS.—In carrying out this subsection, a group health plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

“(C) RULE OF CONSTRUCTION.—

“(i) Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations.

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

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

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

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

lations) or as permitted by the HIPAA privacy regulations.

“(F) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section shall prevent an entity providing pharmacy benefit management services on behalf of a group health plan, from placing reasonable restrictions on the public disclosure of the information contained in a report described in paragraph (1), except that such plan or entity may not—

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

“(ii) prevent disclosure for the purposes of subsection (c), or any other public disclosure requirement under this section.

“(G) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1) required with respect to any group health plan established by a plan sponsor that is, or is affiliated with, a drug manufacturer, drug wholesaler, or other direct participant in the drug

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

3 “(5) STANDARD FORMAT AND REGULATIONS.—

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

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

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

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

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

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

15 “(e) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(h) FUNDING.—

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

18 “(2) LIMITATION.—

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

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

Passed the House of Representatives December 17,
2025.

Attest:

Clerk.

119TH CONGRESS
1ST SESSION

H. R. 6703

AN ACT

To ensure access to affordable health insurance.