AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4507 OFFERED BY MR. GOOD OF VIRGINIA

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Transparency in Coverage Act''.

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

(a) IN GENERAL.—

(1) ERISA.—

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

''SEC. 719. PRICE TRANSPARENCY REQUIREMENTS.

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

''(1) Claims payment policies and practices.

''(2) Periodic financial disclosures.

''(3) Data on enrollment.

''(4) Data on disenrollment.

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

''(6) Data on rating practices.

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

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

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

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

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

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

''(c) COST SHARING TRANSPARENCY.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall, upon request of a participant or beneficiary and in a timely manner, provide to the participant or beneficiary a statement of the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the participant's or beneficiary's plan or coverage that the participant or beneficiary would be responsible for paying with re-

spect to the furnishing of a specific item or service by a provider. At a minimum, such information shall include the information specified in paragraph (2) and shall be made available at no cost to the participant or beneficiary through a self-service tool that meets the requirements of paragraph (3) or through a paper or phone disclosure, at the option of the participant or beneficiary, that meets such requirements as the Secretary may specify.

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

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

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

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

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

the plan or coverage, by such separate deductibles or maximums, in addition to any cumulative deductible or maximum).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(d) RATE AND PAYMENT INFORMATION.—

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

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

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

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

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

''(C) With respect to each item or service for which benefits are available under such plan

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

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

''(2) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such require-

ments as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in the same file or in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans and group health insurance coverage, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

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

''(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan or health insurance issuer under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an applica-

tion program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

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

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

''(4) ANNUAL SUMMARY.—For each year (beginning with 2025), each group health plan and health insurance issuer offering group health insurance coverage shall make public a machine-readable

file meeting such standards as established by the Secretary under paragraph (2) containing a summary of all rate and payment information made public by such plan or issuer with respect to such plan or coverage during such year (such as averages of all such information so made public).

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

''(f) DEFINITIONS.—In this subsection:

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

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

plan or coverage and such provider for such item or service.''.

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

''Sec. 719. Price transparency requirements.''.

(2) IRC.—

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

''SEC. 9819. PRICE TRANSPARENCY REQUIREMENTS.

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

''(1) Claims payment policies and practices.

''(2) Periodic financial disclosures.

''(3) Data on enrollment.

''(4) Data on disenrollment.

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

''(6) Data on rating practices.

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

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

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

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

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

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

template and standardized definitions of terms to allow for comparison across group health plans and health insurance coverage.

''(c) COST SHARING TRANSPARENCY.—

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

''(2) SPECIFIED INFORMATION.—For purposes of paragraph (1), the information specified in this paragraph is, with respect to an item or service for which benefits are available under a group health

plan furnished by a health care provider to a participant or beneficiary of such plan, the following:

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

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

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

determined the amount of payment for such provider, using a reasonable estimate of such percentage of such charges)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(A) allows providers to submit the notifications to such plan or coverage required under

section 2799B–6 of the Public Health Services Act; and

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

''(d) RATE AND PAYMENT INFORMATION.—

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

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

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

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

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

''(C) With respect to each item or service for which benefits are available under such

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

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

''(2) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in dollar amounts through 3 separate machine-readable files corresponding to the information described in each of subparagraphs (A) through (C) of paragraph (1) that meet such require-

ments as specified by the Secretary not later than 180 days after the date of the enactment of this paragraph through rulemaking. Such requirements shall ensure that such files are limited to an appropriate size, do not include information that is duplicative of information contained in other files made available under such subsection, are made available in a widely-available format that allows for information contained in such files to be compared across group health plans, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials.

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

''(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides ac-

cess to such information in real time and that meets such technical standards as may be specified by the Secretary.

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

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

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

(such as averages of all such information so made public).

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

''(f) DEFINITIONS.—In this subsection:

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

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

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

''Sec. 9819. Price transparency requirements.''.

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

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

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

"(1) Claims payment policies and practices.

"(2) Periodic financial disclosures.

"(3) Data on enrollment.

"(4) Data on disenrollment.

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

"(6) Data on rating practices.

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

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

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

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

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

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

''(c) COST SHARING TRANSPARENCY.—

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

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

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

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

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

vider, using a reasonable estimate of such percentage of such charges)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ing health insurance coverage may include functionality that—

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

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

''(d) RATE AND PAYMENT INFORMATION.—

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

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

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

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

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

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

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

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

''(2) MANNER OF PUBLICATION.—

''(A) IN GENERAL.—Rate and payment information required to be made available under subsection (a)(9) shall be so made available in

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

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

''(i) IN GENERAL.—Subject to clause (ii), beginning January 1, 2026, rate and payment information required to be made available by a group health plan or health

insurance issuer under subsection (a)(9) shall, in addition to being made available in the manner described in subparagraph (A), be made available through an application program interface (or successor technology) that provides access to such information in real time and that meets such technical standards as may be specified by the Secretary.

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

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

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

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

''(f) DEFINITIONS.—In this subsection:

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

''(2) IN-NETWORK RATE.—The term 'in-network rate' means, with respect to a group health plan or group or individual health insurance coverage and an item or service furnished by a provider

that is a participating provider with respect to such plan or coverage and item or service, the contracted rate (reflected as a dollar amount) in effect between such plan or coverage and such provider for such item or service.''.

(b) REPORTS TO CONGRESS.—

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

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

in Coverage Act of 2023''), assessing the differences in commercial negotiated prices—

(A) between rural and urban markets;

(B) in the individual, small-employer, and large-employer markets;

(C) in consolidated and non-consolidated provider markets;

(D) between non-profit and for-profit hospitals; and

(E) between non-profit and for-profit insurers.

(c) EFFECTIVE DATE.—

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

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

SEC. 3. PHARMACY BENEFIT MANAGER TRANSPARENCY.

(a) ERISA.—

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

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

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

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

''(b) REPORTS.—

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

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

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

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

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

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

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

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

''(iii) a list of all drugs dispensed by such affiliated pharmacy or pharmacy under common ownership and charged to the plan, issuer, or participants and bene-

ficiaries of the plan, during the applicable period, and, with respect to each drug—

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

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

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

"(III) the interquartile range of the costs, per dosage unit, per 30-day

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

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

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

''(VI) other information with respect to the cost of the drug, as determined by the Secretary, such as average sales price, wholesale acquisition cost, and national average drug acqui-

sition cost per dosage unit or per 30-day supply, and per 90-day supply, for such drug, including amounts charged to the plan or issuer and participants and beneficiaries among all pharmacies included in the network of such plan or coverage; and

''(G) in the case of a large employer—

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

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

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

such drug for which a claim was filed during the reporting period; and

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

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

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

''(V) for any drug for which gross spending of the plan or coverage

exceeded $10,000 during the reporting period—

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

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

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

''(I) total gross spending by the plan;

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

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

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

''(V) for each drug—

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

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

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

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

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

''(2) PRIVACY REQUIREMENTS.—Health insurance issuers offering group health insurance coverage and entities providing pharmacy benefits management services on behalf of a group health plan shall provide information under paragraph (1) in a

manner consistent with the privacy, security, and breach notification regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, and shall restrict the use and disclosure of such information according to such privacy regulations.

''(3) DISCLOSURE AND REDISCLOSURE.—

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

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

of the Treasury, the Comptroller General of the United States, or applicable State agencies.

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

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

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

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

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

''(d) DEFINITIONS.—In this section:

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

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

(B) in section 502 (29 U.S.C. 1132)—

(i) in subsection (a)—

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

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

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

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

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

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

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

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

''(A) FAILURE TO PROVIDE TIMELY INFORMATION.—The Secretary may impose a penalty against any health insurance issuer or entity providing pharmacy benefits management services that violates section 726(a) or fails to provide information required under section 726(b) in the amount of $10,000 for each day during

which such violation continues or such information is not disclosed or reported.

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

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

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

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

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

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

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

''(b) REPORTS.—

''(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan or health insurance issuer offering group health insurance coverage, or an entity providing pharmacy benefits management services on behalf of a group health plan or an issuer providing group health insurance coverage,

shall submit to the plan administrator (as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974) of such plan or coverage a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan or health insurance coverage—

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

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

''(C) total amount received, or expected to be received, by the plan or coverage from any entities, in rebates, fees, alternative discounts, and all other remuneration received from the entity or any third party (including group pur-

chasing organizations) other than the plan administrator, related to utilization of drug or drug spending under such plan or coverage during the reporting period;

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

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

''(F)(i) an explanation of any benefit design parameters that encourage or require participants and beneficiaries in the plan or coverage to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with or under common ownership with the entity providing pharmacy benefit management

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

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

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

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

plan or coverage, to the plan or issuer; and

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

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

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

that are included in the pharmacy network of that plan or coverage;

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

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

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

pharmacies included in the network of such plan or coverage; and

''(G) in the case of a large employer—

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

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

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

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

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

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

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

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

''(aa) a list of all other drugs in the same therapeutic category or class, including brand

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

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

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

''(I) total gross spending by the plan;

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

''(III) if applicable to that category or class, a description of the

formulary tiers and utilization mechanisms (such as prior authorization or step therapy) employed for drugs in that category or class;

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

''(V) for each drug—

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

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

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

''(bb) the total net spending, after deducting rebates, price concessions, alternative discounts

or other remuneration from drug manufacturers, by the health plan or health insurance coverage on that category or class of drugs; and

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

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

''(3) DISCLOSURE AND REDISCLOSURE.—

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

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

''(C) LIMITED FORM OF REPORT.—The Secretary shall define through rulemaking a limited form of the report under paragraph (1)

required of plan administrators who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anti-competitive behavior.

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

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

''(c) ENFORCEMENT.—

''(1) FAILURE TO PROVIDE TIMELY INFORMATION.—An entity providing pharmacy benefits man-

agement services that violates subsection (a) or fails to provide information required under subsection (b) shall be subject to a civil monetary penalty in the amount of $10,000 for each day during which such violation continues or such information is not disclosed or reported.

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

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

''(4) WAIVERS.—The Secretary may waive penalties under paragraph (2), or extend the period of time for compliance with a requirement of this sec-

tion, for an entity in violation of this section that has made a good-faith effort to comply with this section.

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

''(e) DEFINITIONS.—In this section:

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

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

(c) IRC.—

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

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

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

"(b) REPORTS.—

"(1) IN GENERAL.—For plan years beginning on or after January 1, 2025, not less frequently than quarterly (and upon request by the plan administrator), a group health plan, or an entity providing pharmacy benefits management services on behalf of a group health plan, shall submit to the plan admin-

istrator (as defined in section 3(16)(A) of the Employee Retirement Income Security Act of 1974) of such plan a report in accordance with this subsection, and make such report available to the plan administrator in a machine-readable format (or as may be determined by the Secretary, other formats). Each such report shall include, with respect to the applicable group health plan—

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

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

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

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

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

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

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

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

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

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

''(II) the median amount charged to the plan, per dosage unit, per 30-

day supply, and per 90-day supply, including amounts paid by the participants and beneficiaries, when the same drug is dispensed by other pharmacies that are not affiliated with or under common ownership with the entity and that are included in the pharmacy network of such plan;

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

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

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

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

''(G) in the case of a large employer—

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

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

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

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

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

''(IV) the total out-of-pocket spending by participants and beneficiaries on such drug after applica-

tion of any benefits under such plan, including participant and beneficiary spending through copayments, coinsurance, and deductibles (but not including any amounts spent by participants and beneficiaries on drugs not covered under such plan, or for which no claim was submitted to such plan);

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

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

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

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

''(I) total gross spending by the plan;

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

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

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

''(V) for each drug—

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

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

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

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

''(cc) the average net spending per 30-day supply and per 90-day supply, incurred by the plan and its participants and beneficiaries, among all drugs within the therapeutic class for

which a claim was filed during the reporting period.

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

''(3) DISCLOSURE AND REDISCLOSURE.—

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

''(B) CLARIFICATION REGARDING PUBLIC DISCLOSURE OF INFORMATION.—Nothing in this section prevents an entity providing pharmacy benefits management services on behalf of a group health plan from placing reasonable restrictions on the public disclosure of the infor-

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

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

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

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

''(c) ENFORCEMENT.—

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

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

''(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act, other than sub-

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

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

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

''(e) DEFINITIONS.—In this section:

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

calendar year and who employs at least 1 employee on the first day of the plan year.

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

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

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

SEC. 4. INFORMATION ON PRESCRIPTION DRUGS.

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

''SEC. 727. INFORMATION ON PRESCRIPTION DRUGS.

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

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

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

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

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

ance) and, as determined by the Secretary, any other expenditure.''.

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

''Sec. 727. Information on prescription drugs.''.

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

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

(b) MEMBERSHIP.—The Secretary shall appoint members representing end-users of the information described in subsection (a). Vacancies on the Committee

shall be filled by appointment consistent with this subsection not later than 3 months after the vacancy arises.

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

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