

118TH CONGRESS
1ST SESSION

S. 1339

To provide for increased oversight of entities that provide pharmacy benefit management services on behalf of group health plans and health insurance coverage.

IN THE SENATE OF THE UNITED STATES

APRIL 27, 2023

Mr. SANDERS (for himself, Mr. CASSIDY, Mrs. MURRAY, and Mr. MARSHALL) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide for increased oversight of entities that provide pharmacy benefit management services on behalf of group health plans and health insurance coverage.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Pharmacy Benefit
5 Manager Reform Act”.

6 **SEC. 2. OVERSIGHT OF ENTITIES THAT PROVIDE PHAR-**
7 **MACY BENEFIT MANAGEMENT SERVICES.**

8 (a) PHSA.—Title XXVII of the Public Health Serv-
9 ice Act (42 U.S.C. 300gg et seq.) is amended—

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

3 **“SEC. 2799A–11. OVERSIGHT OF ENTITIES THAT PROVIDE**
4 **PHARMACY BENEFIT MANAGEMENT SERV-**
5 **ICES.**

6 “(a) IN GENERAL.—For plan years beginning on or
7 after January 1, 2025, a group health plan or health in-
8 surance issuer offering group health insurance coverage
9 or an entity providing pharmacy benefit management serv-
10 ices on behalf of such a plan or issuer shall not enter into
11 a contract with an applicable entity that limits the dislo-
12 sure of information to plan sponsors in such a manner
13 that prevents the plan or issuer, or an entity providing
14 pharmacy benefit management services on behalf of a plan
15 or issuer, from making the reports described in subsection
16 (b).

17 “(b) REPORTS.—

18 “(1) IN GENERAL.—For plan years beginning
19 on or after January 1, 2025, not less frequently
20 than annually, an entity providing pharmacy benefit
21 management services on behalf of a covered group
22 health plan shall submit to the plan sponsor of such
23 covered group health plan a report in accordance
24 with this subsection and make such report available
25 to the plan sponsor in a machine-readable format

1 and, as the Secretary, the Secretary of Labor, and
2 the Secretary of the Treasury may determine, other
3 formats. Each such report shall include, with respect
4 to the covered group health plan—

5 “(A) as applicable, information collected
6 from drug manufacturers by such issuer or en-
7 tity on the total amount of copayment assist-
8 ance dollars paid, or copayment cards applied,
9 that were funded by the drug manufacturer
10 with respect to the participants and bene-
11 ficiaries in such plan;

12 “(B) a list of each drug covered by such
13 plan or entity providing pharmacy benefit man-
14 agement services that was billed during the re-
15 porting period, including, with respect to each
16 such drug during the reporting period—

17 “(i) the brand name, generic or non-
18 proprietary name, and National Drug
19 Code;

20 “(ii) the number of participants and
21 beneficiaries for whom the drug was billed
22 during the reporting period, the total num-
23 ber of prescription claims for the drug (in-
24 cluding original prescriptions and refills),
25 and the total number of dosage units of

1 the drug dispensed across the reporting pe-
2 riod;

3 “(iii) for each claim or dosage unit de-
4 scribed in clause (ii), the type of dis-
5 pensing channel used, such as retail, mail
6 order, or specialty pharmacy;

7 “(iv) the wholesale acquisition cost,
8 listed as cost per days supply, cost per dos-
9 age unit, and cost per typical course of
10 treatment (as applicable);

11 “(v) the total out-of-pocket spending
12 by participants and beneficiaries on such
13 drug after application of any benefits
14 under the plan or coverage, including par-
15 ticipant and beneficiary spending through
16 copayments, coinsurance, and deductibles,
17 but not including any amounts spent by
18 participants and beneficiaries on drugs not
19 covered under the plan or coverage or for
20 which no claim is submitted to the plan or
21 coverage; and

22 “(vi) for any drug for which gross
23 spending by the plan exceeded \$10,000
24 and that is one of the 50 prescription
25 drugs for which the group health plan

1 spent the most on prescription drug bene-
2 fits during the reporting period—

3 “(I) a list of all other drugs in
4 the same therapeutic class, including
5 brand name drugs and biological
6 products and generic drugs or bio-
7 similar biological products that are in
8 the same therapeutic class as such
9 drug; and

10 “(II) if applicable, the rationale
11 for preferred formulary placement of
12 such drug in that therapeutic class,
13 selected from a list of standard ra-
14 tionales established by the Secretary;

15 “(C) a list of each therapeutic class of
16 drugs that were dispensed under the health
17 plan during the reporting period, and, with re-
18 spect to each such therapeutic class of drugs,
19 during the reporting period—

20 “(i) total gross spending by the plan,
21 before rebates, fees, alternative discounts,
22 or other remuneration;

23 “(ii) the number of participants and
24 beneficiaries who filled a prescription for a
25 drug in that class;

1 “(iii) if applicable to that class, a de-
2 scription of the formulary tiers and utiliza-
3 tion management mechanisms (such as
4 prior authorization or step therapy) em-
5 ployed for drugs in that class;

6 “(iv) the total out-of-pocket spending
7 by participants and beneficiaries, including
8 participant and beneficiary spending
9 through copayments, coinsurance, and
10 deductibles; and

11 “(v) for each therapeutic class under
12 which 3 or more drugs are included on the
13 formulary of such plan—

14 “(I) the amount received, or ex-
15 pected to be received, by such entity,
16 from an applicable entity, in rebates,
17 fees, alternative discounts, or other
18 remuneration that—

19 “(aa) has been paid, or will
20 be paid, by such an applicable
21 entity for claims incurred during
22 the reporting period; or

23 “(bb) is related to utilization
24 of drugs or drug spending;

1 “(II) the total net spending by
2 the health plan on that class of drugs;
3 and

4 “(III) the net price per typical
5 course of treatment or 30-day supply
6 incurred by the health plan and its
7 participants and beneficiaries, after
8 rebates, fees, alternative discounts, or
9 other remuneration provided by an
10 applicable entity, for drugs dispensed
11 within such therapeutic class during
12 the reporting period;

13 “(D) total gross spending on prescription
14 drugs by the plan during the reporting period,
15 before rebates, fees, alternative discounts, or
16 other remuneration provided by an applicable
17 entity;

18 “(E) the total amount received, or ex-
19 pected to be received, by the health plan, from
20 an applicable entity, in rebates, fees, alternative
21 discounts, and other remuneration received
22 from any such entities, related to utilization of
23 drug or drug spending under that health plan
24 during the reporting period;

1 “(F) the total net spending on prescription
2 drugs by the health plan during the reporting
3 period;

4 “(G) amounts paid directly or indirectly in
5 rebates, fees, or any other type of compensation
6 (as defined in section 408(b)(2)(B)(ii)(dd)(AA)
7 of the Employee Retirement Income Security
8 Act of 1974) to brokers, consultants, advisors,
9 or any other individual or firm who referred the
10 group health plan’s business to the pharmacy
11 benefit manager; and

12 “(H) a summary document that includes
13 such information described in subparagraphs
14 (A) through (G) as the Secretary determines
15 useful for plan sponsors for purposes of select-
16 ing pharmacy benefit management services,
17 such as an estimated net price to plan sponsor
18 and participant or beneficiary, a cost per claim,
19 the fee structure or reimbursement model, and
20 estimated cost per participant or beneficiary.

21 “(2) SUPPLEMENTARY REPORTING FOR INTRA-
22 COMPANY PRESCRIPTION DRUG TRANSACTIONS.—

23 “(A) IN GENERAL.—A health insurance
24 issuer offering covered group health insurance
25 coverage or an entity providing pharmacy ben-

1 efit management services under a covered group
2 health plan or covered group health insurance
3 coverage shall submit, together with the report
4 under paragraph (1), a supplementary report
5 every 6 months to the plan sponsor that in-
6 cludes—

7 “(i) an explanation of any benefit de-
8 sign parameters that encourage or require
9 participants and beneficiaries in the plan
10 or coverage to fill prescriptions at mail
11 order, specialty, or retail pharmacies that
12 are wholly or partially-owned by that issuer
13 or entity providing pharmacy benefit man-
14 agement services under such plan or cov-
15 erage, including mandatory mail and spe-
16 cialty home delivery programs, retail and
17 mail auto-refill programs, and copayment
18 incentives funded by an entity providing
19 pharmacy benefit management services;

20 “(ii) the percentage of total prescrip-
21 tions charged to the plan, coverage, or par-
22 ticipants and beneficiaries in the plan or
23 coverage, that were dispensed by mail
24 order, specialty, or retail pharmacies that
25 are wholly or partially-owned by the issuer

1 or entity providing pharmacy benefit man-
2 agement services; and

3 “(iii) a list of all drugs dispensed by
4 such wholly or partially-owned pharmacy
5 and charged to the plan or coverage, or
6 participants and beneficiaries of the plan
7 or coverage, during the applicable quarter,
8 and, with respect to each drug—

9 “(I) the amounts charged, per
10 dosage unit, per course of treatment,
11 per 30-day supply, and per 90-day
12 supply, with respect to participants
13 and beneficiaries in the plan or cov-
14 erage, including amounts charged to
15 the plan or coverage and amounts
16 charged to the participants and bene-
17 ficiaries;

18 “(II) the median amount charged
19 to the plan or coverage, per dosage
20 unit, per course of treatment, per 30-
21 day supply, and per 90-day supply, in-
22 cluding amounts paid by the partici-
23 pants and beneficiaries, when the
24 same drug is dispensed by other phar-
25 macies that are not wholly or par-

1 tially-owned by the issuer or entity
2 and that are included in the pharmacy
3 network of that plan or coverage;

4 “(III) the interquartile range of
5 the costs, per dosage unit, per course
6 of treatment, per 30-day supply, and
7 per 90-day supply, including amounts
8 paid by the participants and bene-
9 ficiaries, when the same drug is dis-
10 pensed by other pharmacies that are
11 not wholly or partially-owned by the
12 issuer or entity and that are included
13 in the pharmacy network of that plan
14 or coverage;

15 “(IV) the lowest cost, per dosage
16 unit, per course of treatment, per 30-
17 day supply, and per 90-day supply,
18 for such drug, including amounts
19 charged to the plan or issuer and par-
20 ticipants and beneficiaries, that is
21 available from any pharmacy included
22 in the network of the plan or cov-
23 erage;

24 “(V) the net acquisition cost per
25 dosage unit and for a 30 day-supply,

1 and the acquisition cost per typical
2 course of treatment, if the drug is
3 subject to a maximum price discount;
4 and

5 “(VI) other information with re-
6 spect to the cost of the drug, as deter-
7 mined by the Secretary, such as aver-
8 age sales price, wholesale acquisition
9 cost, and national average drug acqui-
10 sition cost per dosage unit, per typical
11 course of treatment, or per 30-day
12 supply, for such drug, including
13 amounts charged to the plan or issuer
14 and participants and beneficiaries
15 among all pharmacies included in the
16 network of the plan or coverage.

17 “(B) PLANS AND COVERAGE OFFERED BY
18 SMALL EMPLOYERS.—A health insurance issuer
19 offering covered group health insurance cov-
20 erage that is not covered group health insur-
21 ance coverage or an entity providing pharmacy
22 benefit management services under a group
23 health plan that is not a covered group health
24 plan or under group health insurance coverage
25 that is not covered group health insurance cov-

1 erage that conducts transactions with a wholly
2 or partially-owned pharmacy shall submit, to-
3 gether with the report under paragraph (1), a
4 supplementary report every 6 months to the
5 plan sponsor that includes the information de-
6 scribed in clauses (i) and (ii) of subparagraph
7 (A).

8 “(3) PRIVACY REQUIREMENTS.—

9 “(A) RELATIONSHIP TO HIPAA REGULA-
10 TIONS.—Nothing in this section shall be con-
11 strued to modify the requirements for the cre-
12 ation, receipt, maintenance, or transmission of
13 protected health information under the privacy,
14 security, breach notification, and enforcement
15 regulations in parts 160 and 164 of title 45,
16 Code of Federal Regulations (or successor regu-
17 lations).

18 “(B) REQUIREMENT.—A report submitted
19 under paragraph (1) or (2) shall contain only
20 summary health information, as defined in sec-
21 tion 164.504(a) of title 45, Code of Federal
22 Regulations (or successor regulations).

23 “(C) CLARIFICATION REGARDING CERTAIN
24 DISCLOSURES OF INFORMATION.—

1 “(i) REASONABLE RESTRICTIONS.—
2 Nothing in this section prevents a health
3 insurance issuer offering group health in-
4 surance coverage or an entity providing
5 pharmacy benefit management services on
6 behalf of a group health plan or group
7 health insurance coverage from placing
8 reasonable restrictions on the public disclo-
9 sure of the information contained in a re-
10 port under paragraph (1) or (2).

11 “(ii) LIMITATIONS.—A health insur-
12 ance issuer offering group health insurance
13 coverage or an entity providing pharmacy
14 benefit management services on behalf of a
15 group health plan or group health insur-
16 ance coverage may not restrict disclosure
17 of such reports to the Department of
18 Health and Human Services, the Depart-
19 ment of Labor, the Department of the
20 Treasury, or any other Federal agency re-
21 sponsible for enforcement activities under
22 this section for purposes of enforcement
23 under this section or other applicable law,
24 or to the Comptroller General of the

1 United States in accordance with para-
2 graph (6).

3 “(4) USE AND DISCLOSURE BY PLAN SPON-
4 SORS.—

5 “(A) PROHIBITION.—A plan sponsor may
6 not—

7 “(i) fail or refuse to hire, or dis-
8 charge, any employee, or otherwise dis-
9 criminate against any employee with re-
10 spect to the compensation, terms, condi-
11 tions, or privileges of employment of the
12 employee, because of information sub-
13 mitted under paragraph (1) or (2) attrib-
14 uted to the employee or a dependent of the
15 employee; or

16 “(ii) limit, segregate, or classify the
17 employees of the employer in any way that
18 would deprive or tend to deprive any em-
19 ployee of employment opportunities or oth-
20 erwise adversely affect the status of the
21 employee as an employee, because of infor-
22 mation submitted under paragraph (1) or
23 (2) attributed to the employee or a depend-
24 ent of the employee.

1 “(B) DISCLOSURE AND REDISCLOSURE.—

2 A plan sponsor shall not disclose the informa-
3 tion received under paragraph (1) or (2) ex-
4 cept—

5 “(i) to an occupational or other health
6 researcher if the research is conducted in
7 compliance with the regulations and pro-
8 tections provided for under part 46 of title
9 45, Code of Federal Regulations (or suc-
10 cessor regulations);

11 “(ii) in response to an order of a
12 court, except that the plan sponsor may
13 disclose only the information expressly au-
14 thorized by such order;

15 “(iii) to the Department of Health
16 and Human Services, the Department of
17 Labor, the Department of the Treasury, or
18 other Federal agency responsible for en-
19 forcement activities under this section; or

20 “(iv) to a contractor or agent for pur-
21 poses of health plan administration, if such
22 contractor or agent agrees, in writing, to
23 abide by the same use and disclosure re-
24 strictions as the plan sponsor.

1 “(C) RELATIONSHIP TO HIPAA REGULA-
2 TIONS.—With respect to the regulations pro-
3 mulgated by the Secretary of Health and
4 Human Services under part C of title XI of the
5 Social Security Act and section 264 of the
6 Health Insurance Portability and Accountability
7 Act of 1996, subparagraph (B) does not pro-
8 hibit a covered entity (as defined for purposes
9 of such regulations) from any use or disclosure
10 of health information that is authorized for the
11 covered entity under such regulations. The pre-
12 vious sentence does not affect the authority of
13 such Secretary to modify such regulations.

14 “(D) ENFORCEMENT.—

15 “(i) IN GENERAL.—The powers, pro-
16 cedures, and remedies provided in section
17 207 of the Genetic Information Non-
18 discrimination Act to a person alleging a
19 violation of title II of such Act shall be the
20 powers, procedures, and remedies this sub-
21 paragraph provides for any person alleging
22 a violation of this paragraph.

23 “(ii) PROHIBITION AGAINST RETALIA-
24 TION.—No person shall discriminate
25 against any individual because such indi-

1 vidual has opposed any act or practice
2 made unlawful by this paragraph or be-
3 cause such individual made a charge, testi-
4 fied, assisted, or participated in any man-
5 ner in an investigation, proceeding, or
6 hearing under this paragraph. The rem-
7 edies and procedures otherwise provided
8 for under this subparagraph shall be avail-
9 able to aggrieved individuals with respect
10 to violations of this clause.

11 “(5) ADDITIONAL REPORTING.—

12 “(A) REPORTING WITH RESPECT TO
13 GROUP HEALTH PLANS OFFERED BY SMALL
14 EMPLOYERS.—For plan years beginning on or
15 after January 1, 2025, not less frequently than
16 annually, an entity providing pharmacy benefit
17 management services on behalf of a group
18 health plan that is not a covered group health
19 plan shall submit to the plan sponsor of such
20 group health plan a report in accordance with
21 this paragraph, and make such report available
22 to the plan sponsor in a machine-readable for-
23 mat, and such other formats as the Secretary,
24 the Secretary of Health and Human Services,
25 and the Secretary of the Treasury may deter-

1 mine. Each such report shall include, with re-
2 spect to the applicable group health plan, the
3 information described in subparagraphs (A),
4 (D), (E), (F), (G), and (H) of paragraph (1).

5 “(B) OPT-IN FOR GROUP HEALTH INSUR-
6 ANCE COVERAGE.—

7 “(i) IN GENERAL.—A plan sponsor
8 may, on an annual basis, beginning with
9 plan years beginning on or after January
10 1, 2025, elect to require a health insurance
11 issuer offering group health insurance cov-
12 erage to submit to such plan sponsor a re-
13 port in accordance with this subsection.

14 “(ii) CONTENTS OF REPORTS.—

15 “(I) COVERED GROUP HEALTH
16 INSURANCE COVERAGE.—In the case
17 of an issuer that offers covered group
18 health insurance coverage, a report
19 provided pursuant to clause (i) shall
20 include, with respect to the applicable
21 covered group health insurance cov-
22 erage, the information required under
23 paragraph (1) for covered group
24 health plans.

1 “(II) OTHER GROUP HEALTH IN-
2 SURANCE COVERAGE.—In the case of
3 an issuer that offers group health in-
4 surance coverage that is not covered
5 group health insurance, a report pro-
6 vided pursuant to clause (i) shall in-
7 clude, with respect to the applicable
8 group health insurance coverage, the
9 information described in subpara-
10 graphs (A), (D), (E), (F), and (G) of
11 paragraph (1).

12 “(iii) APPLICATION.—For purposes of
13 reports submitted in accordance with this
14 subparagraph, paragraph (1) shall be ap-
15 plied by substituting ‘group health insur-
16 ance coverage’ or ‘health insurance issuer’,
17 as applicable, for ‘group health plan’,
18 ‘group plan’, and ‘plan’ where such terms
19 appear in such paragraph.

20 “(iv) REQUIRED REPORTING FOR ALL
21 GROUP HEALTH INSURANCE COVERAGE.—
22 Each health insurance issuer of health in-
23 surance coverage shall annually submit the
24 information described in paragraph (1)(H),
25 regardless of whether the plan sponsor

1 made the election described in clause (i)
2 for the applicable year.

3 “(6) SUBMISSIONS TO GAO.—A health insur-
4 ance issuer offering group health insurance coverage
5 or an entity providing pharmacy benefit manage-
6 ment services on behalf of a group health plan shall
7 submit to the Comptroller General of the United
8 States each of the first 2 reports submitted to a
9 plan sponsor under paragraph (1) or (5) with re-
10 spect to such coverage or plan, and other such re-
11 ports as requested, in accordance with the privacy
12 requirements under paragraph (3), and such other
13 information that the Comptroller General determines
14 necessary to carry out the study under section 2(f)
15 of the Pharmacy Benefit Manager Reform Act.

16 “(7) STANDARD FORMATS.—

17 “(A) IN GENERAL.—Not later than June
18 1, 2024, the Secretary, the Secretary of Labor,
19 and the Secretary of the Treasury shall specify,
20 through rulemaking, standard formats for
21 health insurance issuers and entities providing
22 pharmacy benefit management services to sub-
23 mit reports required under this subsection.

24 “(B) LIMITED FORM OF REPORT.—The
25 Secretary, the Secretary of Labor, and the Sec-

1 retary of the Treasury shall define through
2 rulemaking a limited form of the reports under
3 paragraphs (1) and (2) required to be sub-
4 mitted to plan sponsors who also are drug man-
5 ufacturers, drug wholesalers, entities providing
6 pharmacy benefit management services, or
7 other direct participants in the drug supply
8 chain, in order to prevent anti-competitive be-
9 havior.

10 “(c) LIMITATIONS ON SPREAD PRICING.—

11 “(1) IN GENERAL.—For plan years beginning
12 on or after January 1, 2025, a group health plan or
13 health insurance issuer offering group or individual
14 health insurance coverage shall not charge partici-
15 pants and beneficiaries, and an entity providing
16 pharmacy benefit management services under such a
17 plan or coverage shall not charge the plan, issuer, or
18 participants and beneficiaries, a price for a prescrip-
19 tion drug that exceeds the price paid to the phar-
20 macy for such drug, excluding penalties paid by the
21 pharmacy (as described in paragraph (2)) to such
22 plan, issuer, or entity.

23 “(2) RULE OF CONSTRUCTION.—For purposes
24 of paragraph (1), penalties paid by pharmacies in-
25 clude only the following:

1 “(A) A penalty paid if an original claim for
2 a prescription drug was submitted fraudulently
3 by the pharmacy to the plan, issuer, or entity.

4 “(B) A penalty paid if the original claim
5 payment made by the plan, issuer, or entity to
6 the pharmacy was inconsistent with the reim-
7 bursement terms in any contract between the
8 pharmacy and the plan, issuer, or entity.

9 “(C) A penalty paid if the pharmacist serv-
10 ices billed to the plan, issuer, or entity were not
11 rendered by the pharmacy.

12 “(d) FULL REBATE PASS-THROUGH TO PLAN.—

13 “(1) IN GENERAL.—For plan years beginning
14 on or after January 1, 2025, a third-party adminis-
15 trator of a group health plan, a health insurance
16 issuer offering group health insurance coverage, or
17 an entity providing pharmacy benefit management
18 services under such health plan or health insurance
19 coverage shall—

20 “(A) remit 100 percent of rebates, fees, al-
21 ternative discounts, and other remuneration re-
22 ceived from any applicable entity that are re-
23 lated to utilization of drugs under such health
24 plan or health insurance coverage, to the group
25 health plan; and

1 “(B) ensure that any contract entered into
2 by such third-party administrator, health insur-
3 ance issuer, or entity providing pharmacy ben-
4 efit management services with an applicable en-
5 tity remit 100 percent of rebates, fees, alter-
6 native discounts, and other remuneration re-
7 ceived to the third-party administrator, health
8 insurance issuer, or entity providing pharmacy
9 benefit management services.

10 “(2) FORM AND MANNER OF REMITTANCE.—

11 Such rebates, fees, alternative discounts, and other
12 remuneration shall be—

13 “(A) remitted to the group health plan or
14 group health insurance coverage in a timely
15 fashion after the period for which such rebates,
16 fees, alternative discounts, or other remunera-
17 tion is calculated, and in no case later than 90
18 days after the end of such period;

19 “(B) fully disclosed and enumerated to the
20 group health plan sponsor, as described in para-
21 graphs (1) and (4) of subsection (b);

22 “(C) available for audit by the plan spon-
23 sor, or a third-party designated by a plan spon-
24 sor not less than once per plan year; and

1 “(D) returned to the issuer or entity pro-
2 viding pharmaceutical benefit management
3 services by the group health plan if audits by
4 such issuer or entity indicate that the amounts
5 received are incorrect after such amounts have
6 been paid to the group health plan.

7 “(3) AUDIT OF REBATE CONTRACTS.—A third-
8 party administrator of a group health plan, a health
9 insurance issuer offering group health insurance cov-
10 erage, or an entity providing pharmacy benefit man-
11 agement services under such health plan or health
12 insurance coverage shall make rebate contracts with
13 rebate aggregators or drug manufacturers available
14 for audit by such plan sponsor or designated third-
15 party, subject to confidentiality agreements to pre-
16 vent re-disclosure of such contracts.

17 “(4) AUDITORS.—The applicable plan sponsor
18 may select an auditor for purposes of carrying out
19 audits under paragraphs (2)(C) and (3).

20 “(5) RULE OF CONSTRUCTION.—Nothing in
21 this subsection shall be construed to prohibit pay-
22 ments to entities offering pharmacy benefit manage-
23 ment services for bona fide services using a fee
24 structure not contemplated by this subsection, pro-

1 vided that such fees are transparent to group health
2 plans and health insurance issuers.

3 “(e) ENFORCEMENT.—

4 “(1) IN GENERAL.—The Secretary, in consulta-
5 tion with the Secretary of Labor and the Secretary
6 of the Treasury, shall enforce this section.

7 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
8 TION.—A health insurance issuer or an entity pro-
9 viding pharmacy benefit management services that
10 violates subsection (a) or fails to provide information
11 required under subsection (b); a group health plan,
12 health insurance issuer, or entity providing phar-
13 macy benefit management services that violates sub-
14 section (c); or a third-party administrator of a group
15 health plan, a health insurance issuer offering group
16 health insurance coverage, or an entity providing
17 pharmacy benefit management services that violates
18 subsection (d) shall be subject to a civil monetary
19 penalty in the amount of \$10,000 for each day dur-
20 ing which such violation continues or such informa-
21 tion is not disclosed or reported.

22 “(3) FALSE INFORMATION.—A health insurance
23 issuer, entity providing pharmacy benefit manage-
24 ment services, or drug manufacturer that knowingly
25 provides false information under this section shall be

1 subject to a civil money penalty in an amount not
2 to exceed \$100,000 for each item of false informa-
3 tion. Such civil money penalty shall be in addition to
4 other penalties as may be prescribed by law.

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

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

19 “(f) RULE OF CONSTRUCTION.—Nothing in this sec-
20 tion shall be construed to permit a health insurance issuer,
21 group health plan, or other entity to restrict disclosure to,
22 or otherwise limit the access of, the Department of Health
23 and Human Services to a report described in subsection
24 (b)(1) or information related to compliance with sub-
25 section (a) by such issuer, plan, or entity.

1 “(g) DEFINITIONS.—In this section—

2 “(1) the term ‘applicable entity’ means—

3 “(A) a drug manufacturer, distributor,
4 wholesaler, rebate aggregator (or other pur-
5 chasing entity designed to aggregate rebates),
6 group purchasing organization, or associated
7 third party;

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

14 “(C) such other entity as the Secretary,
15 the Secretary of Labor, and the Secretary of
16 the Treasury may specify through rulemaking;

17 “(2) the term ‘covered group health insurance
18 coverage’ means health insurance coverage offered in
19 connection with a group health plan maintained by
20 a large employer;

21 “(3) the term ‘covered group health plan’
22 means a group health plan maintained by a large
23 employer;

24 “(4) the term ‘gross spending’, with respect to
25 prescription drug benefits under a group health plan

1 or health insurance coverage, means the amount
2 spent by a group health plan or health insurance
3 issuer on prescription drug benefits, calculated be-
4 fore the application of manufacturer rebates, fees,
5 alternative discounts, or other remuneration;

6 “(5) the term ‘large employer’ means, in con-
7 nection with a group health plan with respect to a
8 calendar year and a plan year, an employer who em-
9 ployed an average of at least 50 employees on busi-
10 ness days during the preceding calendar year and
11 who employs at least 1 employee on the first day of
12 the plan year;

13 “(6) the term ‘net spending’, with respect to
14 prescription drug benefits under a group health plan
15 or health insurance coverage, means the amount
16 spent by a group health plan or health insurance
17 issuer on prescription drug benefits, calculated after
18 the application of manufacturer rebates, fees, alter-
19 native discounts, or other remuneration;

20 “(7) the term ‘plan sponsor’ has the meaning
21 given such term in section 3(16)(B) of the Employee
22 Retirement Income Security Act of 1974;

23 “(8) the term ‘remuneration’ has the meaning
24 given such term by the Secretary, the Secretary of

1 Labor, and the Secretary of the Treasury, through
2 notice and comment rulemaking;

3 “(9) the term ‘small employer’ means, in con-
4 nection with a group health plan with respect to a
5 calendar year and a plan year, an employer who em-
6 ployed an average of at least 1 but not more than
7 49 employees on business days during the preceding
8 calendar year and who employs at least 1 employee
9 on the first day of the plan year; and

10 “(10) the term ‘wholesale acquisition cost’ has
11 the meaning given such term in section
12 1847A(c)(6)(B) of the Social Security Act.”; and

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

14 (A) in subsection (a)—

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

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

21 (B) in subsection (b)—

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

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

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

7 (b) ERISA.—

8 (1) IN GENERAL.—Subtitle B of title I of the
 9 Employee Retirement Income Security Act of 1974
 10 (29 U.S.C. 1021 et seq.) is amended—

11 (A) in subpart B of part 7 (29 U.S.C.
 12 1185 et seq.), by adding at the end the fol-
 13 lowing:

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

16 “(a) IN GENERAL.—For plan years beginning on or
 17 after January 1, 2025, a group health plan (or health in-
 18 surance issuer offering group health insurance coverage
 19 in connection with such a plan) or an entity providing
 20 pharmacy benefit management services on behalf of such
 21 a plan or issuer shall not enter into a contract with an
 22 applicable entity that limits the disclosure of information
 23 to plan sponsors in such a manner that prevents the plan
 24 or issuer, or an entity providing pharmacy benefit manage-

1 ment services on behalf of a plan or issuer, from making
2 the reports described in subsection (b).

3 “(b) REPORTS.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after January 1, 2025, not less frequently
6 than annually, an entity providing pharmacy benefit
7 management services on behalf of a covered group
8 health plan shall submit to the plan sponsor of such
9 covered group health plan a report in accordance
10 with this subsection and make such report available
11 to the plan sponsor in a machine-readable format
12 and, as the Secretary may determine, other formats.
13 Each such report shall include, with respect to the
14 covered group health plan—

15 “(A) as applicable, information collected
16 from drug manufacturers by such issuer or en-
17 tity on the total amount of copayment assist-
18 ance dollars paid, or copayment cards applied,
19 that were funded by the drug manufacturer
20 with respect to the participants and bene-
21 ficiaries in such plan;

22 “(B) a list of each drug covered by such
23 plan or entity providing pharmacy benefit man-
24 agement services that was billed during the re-

1 porting period, including, with respect to each
2 such drug during the reporting period—

3 “(i) the brand name, generic or non-
4 proprietary name, and National Drug
5 Code;

6 “(ii) the number of participants and
7 beneficiaries for whom the drug was billed
8 during the reporting period, the total num-
9 ber of prescription claims for the drug (in-
10 cluding original prescriptions and refills),
11 and the total number of dosage units of
12 the drug dispensed across the reporting pe-
13 riod;

14 “(iii) for each claim or dosage unit de-
15 scribed in clause (ii), the type of dis-
16 pensing channel used, such as retail, mail
17 order, or specialty pharmacy;

18 “(iv) the wholesale acquisition cost,
19 listed as cost per days supply, cost per dos-
20 age unit, and cost per typical course of
21 treatment (as applicable);

22 “(v) the total out-of-pocket spending
23 by participants and beneficiaries on such
24 drug after application of any benefits
25 under the plan or coverage, including par-

1 participant and beneficiary spending through
2 copayments, coinsurance, and deductibles,
3 but not including any amounts spent by
4 participants and beneficiaries on drugs not
5 covered under the plan or coverage or for
6 which no claim is submitted to the plan or
7 coverage; and

8 “(vi) for any drug for which gross
9 spending by the plan exceeded \$10,000
10 and that is one of the 50 prescription
11 drugs for which the group health plan
12 spent the most on prescription drug bene-
13 fits during the reporting period—

14 “(I) a list of all other drugs in
15 the same therapeutic class, including
16 brand name drugs and biological
17 products and generic drugs or bio-
18 similar biological products that are in
19 the same therapeutic class as such
20 drug; and

21 “(II) if applicable, the rationale
22 for preferred formulary placement of
23 such drug in that therapeutic class,
24 selected from a list of standard ra-
25 tionales established by the Secretary;

1 “(C) a list of each therapeutic class of
2 drugs that were dispensed under the health
3 plan during the reporting period, and, with re-
4 spect to each such therapeutic class of drugs,
5 during the reporting period—

6 “(i) total gross spending by the plan,
7 before rebates, fees, alternative discounts,
8 or other remuneration;

9 “(ii) the number of participants and
10 beneficiaries who filled a prescription for a
11 drug in that class;

12 “(iii) if applicable to that class, a de-
13 scription of the formulary tiers and utiliza-
14 tion management mechanisms (such as
15 prior authorization or step therapy) em-
16 ployed for drugs in that class;

17 “(iv) the total out-of-pocket spending
18 by participants and beneficiaries, including
19 participant and beneficiary spending
20 through copayments, coinsurance, and
21 deductibles; and

22 “(v) for each therapeutic class under
23 which 3 or more drugs are included on the
24 formulary of such plan—

1 “(I) the amount received, or ex-
2 pected to be received, by such entity,
3 from an applicable entity, in rebates,
4 fees, alternative discounts, or other
5 remuneration that—

6 “(aa) has been paid, or will
7 be paid, by such an applicable
8 entity for claims incurred during
9 the reporting period; or

10 “(bb) is related to utilization
11 of drugs or drug spending;

12 “(II) the total net spending by
13 the health plan on that class of drugs;
14 and

15 “(III) the net price per typical
16 course of treatment or 30-day supply
17 incurred by the health plan and its
18 participants and beneficiaries, after
19 rebates, fees, alternative discounts, or
20 other remuneration provided by an
21 applicable entity, for drugs dispensed
22 within such therapeutic class during
23 the reporting period;

24 “(D) total gross spending on prescription
25 drugs by the plan during the reporting period,

1 before rebates, fees, alternative discounts, or
2 other remuneration provided by an applicable
3 entity;

4 “(E) the total amount received, or ex-
5 pected to be received, by the health plan, from
6 an applicable entity, in rebates, fees, alternative
7 discounts, and other remuneration received
8 from any such entities, related to utilization of
9 drug or drug spending under that health plan
10 during the reporting period;

11 “(F) the total net spending on prescription
12 drugs by the health plan during the reporting
13 period;

14 “(G) amounts paid directly or indirectly in
15 rebates, fees, or any other type of compensation
16 (as defined in section 408(b)(2)(B)(ii)(dd)(AA))
17 to brokers, consultants, advisors, or any other
18 individual or firm who referred the group health
19 plan’s business to the pharmacy benefit man-
20 ager; and

21 “(H) a summary document that includes
22 such information described in subparagraphs
23 (A) through (G) as the Secretary determines
24 useful for plan sponsors for purposes of select-
25 ing pharmacy benefit management services,

1 such as an estimated net price to plan sponsor
2 and participant or beneficiary, a cost per claim,
3 the fee structure or reimbursement model, and
4 estimated cost per participant or beneficiary.

5 “(2) SUPPLEMENTARY REPORTING FOR INTRA-
6 COMPANY PRESCRIPTION DRUG TRANSACTIONS.—

7 “(A) IN GENERAL.—A health insurance
8 issuer offering covered group health insurance
9 coverage or an entity providing pharmacy ben-
10 efit management services under a covered group
11 health plan or covered group health insurance
12 coverage shall submit, together with the report
13 under paragraph (1), a supplementary report
14 every 6 months to the plan sponsor that in-
15 cludes—

16 “(i) an explanation of any benefit de-
17 sign parameters that encourage or require
18 participants and beneficiaries in the plan
19 or coverage to fill prescriptions at mail
20 order, specialty, or retail pharmacies that
21 are wholly or partially-owned by that issuer
22 or entity providing pharmacy benefit man-
23 agement services under such plan or cov-
24 erage, including mandatory mail and spe-
25 cialty home delivery programs, retail and

1 mail auto-refill programs, and copayment
2 incentives funded by an entity providing
3 pharmacy benefit management services;

4 “(ii) the percentage of total prescrip-
5 tions charged to the plan, coverage, or par-
6 ticipants and beneficiaries in the plan or
7 coverage, that were dispensed by mail
8 order, specialty, or retail pharmacies that
9 are wholly or partially-owned by the issuer
10 or entity providing pharmacy benefit man-
11 agement services; and

12 “(iii) a list of all drugs dispensed by
13 such wholly or partially-owned pharmacy
14 and charged to the plan or coverage, or
15 participants and beneficiaries of the plan
16 or coverage, during the applicable quarter,
17 and, with respect to each drug—

18 “(I) the amounts charged, per
19 dosage unit, per course of treatment,
20 per 30-day supply, and per 90-day
21 supply, with respect to participants
22 and beneficiaries in the plan or cov-
23 erage, including amounts charged to
24 the plan or coverage and amounts

1 charged to the participants and bene-
2 ficiaries;

3 “(II) the median amount charged
4 to the plan or coverage, per dosage
5 unit, per course of treatment, per 30-
6 day supply, and per 90-day supply, in-
7 cluding amounts paid by the partici-
8 pants and beneficiaries, when the
9 same drug is dispensed by other phar-
10 macies that are not wholly or par-
11 tially-owned by the issuer or entity
12 and that are included in the pharmacy
13 network of that plan or coverage;

14 “(III) the interquartile range of
15 the costs, per dosage unit, per course
16 of treatment, per 30-day supply, and
17 per 90-day supply, including amounts
18 paid by the participants and bene-
19 ficiaries, when the same drug is dis-
20 pensed by other pharmacies that are
21 not wholly or partially-owned by the
22 issuer or entity and that are included
23 in the pharmacy network of that plan
24 or coverage;

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

10 “(V) the net acquisition cost per
11 dosage unit and for a 30 day-supply,
12 and the acquisition cost per typical
13 course of treatment, if the drug is
14 subject to a maximum price discount;
15 and

16 “(VI) other information with re-
17 spect to the cost of the drug, as deter-
18 mined by the Secretary, such as aver-
19 age sales price, wholesale acquisition
20 cost, and national average drug acqui-
21 sition cost per dosage unit, per typical
22 course of treatment, or per 30-day
23 supply, for such drug, including
24 amounts charged to the plan or issuer
25 and participants and beneficiaries

1 among all pharmacies included in the
2 network of the plan or coverage.

3 “(B) PLANS AND COVERAGE OFFERED BY
4 SMALL EMPLOYERS.—A health insurance issuer
5 offering covered group health insurance cov-
6 erage that is not covered group health insur-
7 ance coverage or an entity providing pharmacy
8 benefit management services under a group
9 health plan that is not a covered group health
10 plan or under group health insurance coverage
11 that is not covered group health insurance cov-
12 erage that conducts transactions with a wholly
13 or partially-owned pharmacy shall submit, to-
14 gether with the report under paragraph (1), a
15 supplementary report every 6 months to the
16 plan sponsor that includes the information de-
17 scribed in clauses (i) and (ii) of subparagraph
18 (A).

19 “(3) PRIVACY REQUIREMENTS.—

20 “(A) RELATIONSHIP TO HIPAA REGULA-
21 TIONS.—Nothing in this section shall be con-
22 strued to modify the requirements for the cre-
23 ation, receipt, maintenance, or transmission of
24 protected health information under the privacy,
25 security, breach notification, and enforcement

1 regulations in parts 160 and 164 of title 45,
2 Code of Federal Regulations (or successor regu-
3 lations).

4 “(B) REQUIREMENT.—A report submitted
5 under paragraph (1) or (2) shall contain only
6 summary health information, as defined in sec-
7 tion 164.504(a) of title 45, Code of Federal
8 Regulations (or successor regulations).

9 “(C) CLARIFICATION REGARDING CERTAIN
10 DISCLOSURES OF INFORMATION.—

11 “(i) REASONABLE RESTRICTIONS.—
12 Nothing in this section prevents a health
13 insurance issuer offering group health in-
14 surance coverage or an entity providing
15 pharmacy benefit management services on
16 behalf of a group health plan or group
17 health insurance coverage from placing
18 reasonable restrictions on the public disclo-
19 sure of the information contained in a re-
20 port under paragraph (1) or (2).

21 “(ii) LIMITATIONS.—A health insur-
22 ance issuer offering group health insurance
23 coverage or an entity providing pharmacy
24 benefit management services on behalf of a
25 group health plan or group health insur-

1 ance coverage may not restrict disclosure
2 of such reports to the Department of
3 Health and Human Services, the Depart-
4 ment of Labor, the Department of the
5 Treasury, or any other Federal agency re-
6 sponsible for enforcement activities under
7 this section for purposes of enforcement
8 under this section or other applicable law,
9 or to the Comptroller General of the
10 United States in accordance with para-
11 graph (6).

12 “(4) USE AND DISCLOSURE BY PLAN SPON-
13 SORS.—

14 “(A) PROHIBITION.—A plan sponsor may
15 not—

16 “(i) fail or refuse to hire, or dis-
17 charge, any employee, or otherwise dis-
18 criminate against any employee with re-
19 spect to the compensation, terms, condi-
20 tions, or privileges of employment of the
21 employee, because of information sub-
22 mitted under paragraph (1) or (2) attrib-
23 uted to the employee or a dependent of the
24 employee; or

1 “(ii) limit, segregate, or classify the
2 employees of the employer in any way that
3 would deprive or tend to deprive any em-
4 ployee of employment opportunities or oth-
5 erwise adversely affect the status of the
6 employee as an employee, because of infor-
7 mation submitted under paragraph (1) or
8 (2) attributed to the employee or a depend-
9 ent of the employee.

10 “(B) DISCLOSURE AND REDISCLOSURE.—

11 A plan sponsor shall not disclose the informa-
12 tion received under paragraph (1) or (2) ex-
13 cept—

14 “(i) to an occupational or other health
15 researcher if the research is conducted in
16 compliance with the regulations and pro-
17 tections provided for under part 46 of title
18 45, Code of Federal Regulations (or suc-
19 cessor regulations);

20 “(ii) in response to an order of a
21 court, except that the plan sponsor may
22 disclose only the information expressly au-
23 thorized by such order;

24 “(iii) to the Department of Health
25 and Human Services, the Department of

1 Labor, the Department of the Treasury, or
2 other Federal agency responsible for en-
3 forcement activities under this section; or

4 “(iv) to a contractor or agent for pur-
5 poses of health plan administration, if such
6 contractor or agent agrees, in writing, to
7 abide by the same use and disclosure re-
8 strictions as the plan sponsor.

9 “(C) RELATIONSHIP TO HIPAA REGULA-
10 TIONS.—With respect to the regulations pro-
11 mulgated by the Secretary of Health and
12 Human Services under part C of title XI of the
13 Social Security Act (42 U.S.C. 1320d et seq.)
14 and section 264 of the Health Insurance Port-
15 ability and Accountability Act of 1996 (42
16 U.S.C. 1320d–2), subparagraph (B) does not
17 prohibit a covered entity (as defined for pur-
18 poses of such regulations) from any use or dis-
19 closure of health information that is authorized
20 for the covered entity under such regulations.
21 The previous sentence does not affect the au-
22 thority of such Secretary to modify such regula-
23 tions.

24 “(D) ENFORCEMENT.—

1 “(i) IN GENERAL.—The powers, pro-
2 cedures, and remedies provided in section
3 207 of the Genetic Information Non-
4 discrimination Act (42 U.S.C. 2000ff–6) to
5 a person alleging a violation of title II of
6 such Act shall be the powers, procedures,
7 and remedies this subparagraph provides
8 for any person alleging a violation of this
9 paragraph.

10 “(ii) PROHIBITION AGAINST RETALIA-
11 TION.—No person shall discriminate
12 against any individual because such indi-
13 vidual has opposed any act or practice
14 made unlawful by this paragraph or be-
15 cause such individual made a charge, testi-
16 fied, assisted, or participated in any man-
17 ner in an investigation, proceeding, or
18 hearing under this paragraph. The rem-
19 edies and procedures otherwise provided
20 for under this subparagraph shall be avail-
21 able to aggrieved individuals with respect
22 to violations of this clause.

23 “(5) ADDITIONAL REPORTING.—

24 “(A) REPORTING WITH RESPECT TO
25 GROUP HEALTH PLANS OFFERED BY SMALL

1 EMPLOYERS.—For plan years beginning on or
2 after January 1, 2025, not less frequently than
3 annually, an entity providing pharmacy benefit
4 management services on behalf of a group
5 health plan that is not a covered group health
6 plan shall submit to the plan sponsor of such
7 group health plan a report in accordance with
8 this paragraph, and make such report available
9 to the plan sponsor in a machine-readable for-
10 mat, and such other formats as the Secretary,
11 the Secretary of Health and Human Services,
12 and the Secretary of Labor may determine.
13 Each such report shall include, with respect to
14 the applicable group health plan, the informa-
15 tion described in subparagraphs (A), (D), (E),
16 (F), (G), and (H) of paragraph (1).

17 “(B) OPT-IN FOR GROUP HEALTH INSUR-
18 ANCE COVERAGE.—

19 “(i) IN GENERAL.—A plan sponsor
20 may, on an annual basis, beginning with
21 plan years beginning on or after January
22 1, 2025, elect to require a health insurance
23 issuer offering group health insurance cov-
24 erage to submit to such plan sponsor a re-
25 port in accordance with this subsection.

1 “(ii) CONTENTS OF REPORTS.—

2 “(I) COVERED GROUP HEALTH
3 INSURANCE COVERAGE.—In the case
4 of an issuer that offers covered group
5 health insurance coverage, a report
6 provided pursuant to clause (i) shall
7 include, with respect to the applicable
8 covered group health insurance cov-
9 erage, the information required under
10 paragraph (1) for covered group
11 health plans.

12 “(II) OTHER GROUP HEALTH IN-
13 SURANCE COVERAGE.—In the case of
14 an issuer that offers group health in-
15 surance coverage that is not covered
16 group health insurance, a report pro-
17 vided pursuant to clause (i) shall in-
18 clude, with respect to the applicable
19 group health insurance coverage, the
20 information described in subpara-
21 graphs (A), (D), (E), (F), and (G) of
22 paragraph (1).

23 “(iii) APPLICATION.—For purposes of
24 reports submitted in accordance with this
25 subparagraph, paragraph (1) shall be ap-

1 plied by substituting ‘group health insur-
2 ance coverage’ or ‘health insurance issuer’,
3 as applicable, for ‘group health plan’,
4 ‘group plan’, and ‘plan’ where such terms
5 appear in such paragraph.

6 “(iv) REQUIRED REPORTING FOR ALL
7 GROUP HEALTH INSURANCE COVERAGE.—
8 Each health insurance issuer of health in-
9 surance coverage shall annually submit the
10 information described in paragraph (1)(H),
11 regardless of whether the plan sponsor
12 made the election described in clause (i)
13 for the applicable year.

14 “(6) SUBMISSIONS TO GAO.—A health insur-
15 ance issuer offering group health insurance coverage
16 or an entity providing pharmacy benefit manage-
17 ment services on behalf of a group health plan shall
18 submit to the Comptroller General of the United
19 States each of the first 2 reports submitted to a
20 plan sponsor under paragraph (1) or (5) with re-
21 spect to such coverage or plan, and other such re-
22 ports as requested, in accordance with the privacy
23 requirements under paragraph (3), and such other
24 information that the Comptroller General determines

1 necessary to carry out the study under section 2(f)
2 of the Pharmacy Benefit Manager Reform Act.

3 “(7) STANDARD FORMATS.—

4 “(A) IN GENERAL.—Not later than June
5 1, 2024, the Secretary, the Secretary of Health
6 and Human Services, and the Secretary of the
7 Treasury shall specify, through rulemaking,
8 standard formats for health insurance issuers
9 and entities providing pharmacy benefit man-
10 agement services to submit reports required
11 under this subsection.

12 “(B) LIMITED FORM OF REPORT.—The
13 Secretary, the Secretary of Health and Human
14 Services, and the Secretary of the Treasury
15 shall define through rulemaking a limited form
16 of the reports under paragraphs (1) and (2) re-
17 quired to be submitted to plan sponsors who
18 also are drug manufacturers, drug wholesalers,
19 entities providing pharmacy benefit manage-
20 ment services, or other direct participants in
21 the drug supply chain, in order to prevent anti-
22 competitive behavior.

23 “(c) LIMITATIONS ON SPREAD PRICING.—

24 “(1) IN GENERAL.—For plan years beginning
25 on or after January 1, 2025, a group health plan or

1 health insurance issuer offering group health insur-
2 ance coverage shall not charge participants and
3 beneficiaries, and an entity providing pharmacy ben-
4 efit management services under such a plan or cov-
5 erage shall not charge the plan, issuer, or partici-
6 pants and beneficiaries, a price for a prescription
7 drug that exceeds the price paid to the pharmacy for
8 such drug, excluding penalties paid by the pharmacy
9 (as described in paragraph (2)) to such plan, issuer,
10 or entity.

11 “(2) RULE OF CONSTRUCTION.—For purposes
12 of paragraph (1), penalties paid by pharmacies in-
13 clude only the following:

14 “(A) A penalty paid if an original claim for
15 a prescription drug was submitted fraudulently
16 by the pharmacy to the plan, issuer, or entity.

17 “(B) A penalty paid if the original claim
18 payment made by the plan, issuer, or entity to
19 the pharmacy was inconsistent with the reim-
20 bursement terms in any contract between the
21 pharmacy and the plan, issuer, or entity.

22 “(C) A penalty paid if the pharmacist serv-
23 ices billed to the plan, issuer, or entity were not
24 rendered by the pharmacy.

25 “(d) FULL REBATE PASS-THROUGH TO PLAN.—

1 “(1) IN GENERAL.—For plan years beginning
2 on or after January 1, 2025, a third-party adminis-
3 trator of a group health plan, a health insurance
4 issuer offering group health insurance coverage, or
5 an entity providing pharmacy benefit management
6 services under such health plan or health insurance
7 coverage shall—

8 “(A) remit 100 percent of rebates, fees, al-
9 ternative discounts, and other applicable remu-
10 neration received from any applicable entity
11 that are related to utilization of drugs under
12 such health plan or health insurance coverage,
13 to the group health plan; and

14 “(B) ensure that any contract entered into
15 by such third-party administrator, health insur-
16 ance issuer, or entity providing pharmacy ben-
17 efit management services with an applicable en-
18 tity remit 100 percent of rebates, fees, alter-
19 native discounts, and other remuneration re-
20 ceived to the third-party administrator, health
21 insurance issuer, or entity providing pharmacy
22 benefit management services.

23 “(2) FORM AND MANNER OF REMITTANCE.—
24 Such rebates, fees, alternative discounts, and other
25 remuneration shall be—

1 “(A) remitted to the group health plan or
2 group health insurance coverage in a timely
3 fashion after the period for which such rebates,
4 fees, alternative discounts, or other remunera-
5 tion is calculated, and in no case later than 90
6 days after the end of such period;

7 “(B) fully disclosed and enumerated to the
8 group health plan sponsor, as described in para-
9 graphs (1) and (4) of subsection (b);

10 “(C) available for audit by the plan spon-
11 sor, or a third-party designated by a plan spon-
12 sor not less than once per plan year; and

13 “(D) returned to the issuer or entity pro-
14 viding pharmaceutical benefit management
15 services by the group health plan if audits by
16 such issuer or entity indicate that the amounts
17 received are incorrect after such amounts have
18 been paid to the group health plan.

19 “(3) AUDIT OF REBATE CONTRACTS.—A third-
20 party administrator of a group health plan, a health
21 insurance issuer offering group health insurance cov-
22 erage, or an entity providing pharmacy benefit man-
23 agement services under such health plan or health
24 insurance coverage shall make rebate contracts with
25 rebate aggregators or drug manufacturers available

1 for audit by such plan sponsor or designated third-
2 party, subject to confidentiality agreements to pre-
3 vent re-disclosure of such contracts.

4 “(4) AUDITORS.—The applicable plan sponsor
5 may select an auditor for purposes of carrying out
6 audits under paragraphs (2)(C) and (3).

7 “(5) RULE OF CONSTRUCTION.—Nothing in
8 this subsection shall be construed to prohibit pay-
9 ments to entities offering pharmacy benefit manage-
10 ment services for bona fide services using a fee
11 structure not contemplated by this subsection, pro-
12 vided that such fees are transparent to group health
13 plans and health insurance issuers.

14 “(e) ENFORCEMENT.—

15 “(1) IN GENERAL.—The Secretary, in consulta-
16 tion with the Secretary of Health and Human Serv-
17 ices and the Secretary of the Treasury, shall enforce
18 this section.

19 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
20 TION.—A health insurance issuer or an entity pro-
21 viding pharmacy benefit management services that
22 violates subsection (a) or fails to provide information
23 required under subsection (b); a group health plan,
24 health insurance issuer, or entity providing phar-
25 macy benefit management services that violates sub-

1 section (c); or a third-party administrator of a group
2 health plan, a health insurance issuer offering group
3 health insurance coverage, or an entity providing
4 pharmacy benefit management services that violates
5 subsection (d) shall be subject to a civil monetary
6 penalty in the amount of \$10,000 for each day dur-
7 ing which such violation continues or such informa-
8 tion is not disclosed or reported.

9 “(3) FALSE INFORMATION.—A health insurance
10 issuer, entity providing pharmacy benefit manage-
11 ment services, or drug manufacturer that knowingly
12 provides false information under this section shall be
13 subject to a civil money penalty in an amount not
14 to exceed \$100,000 for each item of false informa-
15 tion. Such civil money penalty shall be in addition to
16 other penalties as may be prescribed by law.

17 “(4) PROCEDURE.—The provisions of section
18 1128A of the Social Security Act, other than sub-
19 sections (a) and (b) and the first sentence of sub-
20 section (c)(1) of such section shall apply to civil
21 monetary penalties under this subsection in the
22 same manner as such provisions apply to a penalty
23 or proceeding under section 1128A of the Social Se-
24 curity Act.

1 “(5) WAIVERS.—The Secretary may waive pen-
2 alties under paragraph (2), or extend the period of
3 time for compliance with a requirement of this sec-
4 tion, for an entity in violation of this section that
5 has made a good-faith effort to comply with this sec-
6 tion.

7 “(f) RULE OF CONSTRUCTION.—Nothing in this sec-
8 tion shall be construed to permit a health insurance issuer,
9 group health plan, or other entity to restrict disclosure to,
10 or otherwise limit the access of, the Department of Labor
11 to a report described in subsection (b)(1) or information
12 related to compliance with subsection (a) by such issuer,
13 plan, or entity.

14 “(g) DEFINITIONS.—In this section—

15 “(1) the term ‘applicable entity’ means—

16 “(A) a drug manufacturer, distributor,
17 wholesaler, rebate aggregator (or other pur-
18 chasing entity designed to aggregate rebates),
19 group purchasing organization, or associated
20 third party;

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

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

3 “(C) such other entity as the Secretary,
4 the Secretary of Health and Human Services,
5 and the Secretary of the Treasury may specify
6 through rulemaking;

7 “(2) the term ‘covered group health insurance
8 coverage’ means health insurance coverage offered in
9 connection with a group health plan maintained by
10 a large employer;

11 “(3) the term ‘covered group health plan’
12 means a group health plan maintained by a large
13 employer;

14 “(4) the term ‘gross spending’, with respect to
15 prescription drug benefits under a group health plan
16 or health insurance coverage, means the amount
17 spent by a group health plan or health insurance
18 issuer on prescription drug benefits, calculated be-
19 fore the application of manufacturer rebates, fees,
20 alternative discounts, or other remuneration;

21 “(5) the term ‘large employer’ means, in con-
22 nection with a group health plan with respect to a
23 calendar year and a plan year, an employer who em-
24 ployed an average of at least 50 employees on busi-
25 ness days during the preceding calendar year and

1 who employs at least 1 employee on the first day of
2 the plan year;

3 “(6) the term ‘net spending’, with respect to
4 prescription drug benefits under a group health plan
5 or health insurance coverage, means the amount
6 spent by a group health plan or health insurance
7 issuer on prescription drug benefits, calculated after
8 the application of manufacturer rebates, fees, alter-
9 native discounts, or other remuneration;

10 “(7) the term ‘plan sponsor’ has the meaning
11 given such term in section 3(16)(B);

12 “(8) the term ‘remuneration’ has the meaning
13 given such term by the Secretary, the Secretary of
14 Health and Human Services, and the Secretary of
15 the Treasury, through notice and comment rule-
16 making;

17 “(9) the term ‘small employer’ means, in con-
18 nection with a group health plan with respect to a
19 calendar year and a plan year, an employer who em-
20 ployed an average of at least 1 but not more than
21 49 employees on business days during the preceding
22 calendar year and who employs at least 1 employee
23 on the first day of the plan year; and

24 “(10) the term ‘wholesale acquisition cost’ has
25 the meaning given such term in section

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

3 (B) in section 502(b)(3) (29 U.S.C.
4 1132(b)(3)), by inserting “(other than section
5 726)” after “part 7”.

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

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

11 (c) INTERNAL REVENUE CODE.—

12 (1) IN GENERAL.—Subchapter B of chapter
13 100 of the Internal Revenue Code of 1986 is amend-
14 ed by adding at the end the following:

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

17 “(a) IN GENERAL.—For plan years beginning on or
18 after January 1, 2025, a group health plan or an entity
19 providing pharmacy benefit management services on be-
20 half of such a plan shall not enter into a contract with
21 an applicable entity that limits the disclosure of informa-
22 tion to plan sponsors in such a manner that prevents the
23 plan, or an entity providing pharmacy benefit management

1 services on behalf of a plan, from making the reports de-
2 scribed in subsection (b).

3 “(b) REPORTS.—

4 “(1) IN GENERAL.—For plan years beginning
5 on or after January 1, 2025, not less frequently
6 than annually, an entity providing pharmacy benefit
7 management services on behalf of a covered group
8 health plan shall submit to the plan sponsor of such
9 covered group health plan a report in accordance
10 with this subsection and make such report available
11 to the plan sponsor in a machine-readable format
12 and, as the Secretary may determine, other formats.
13 Each such report shall include, with respect to the
14 covered group health plan—

15 “(A) as applicable, information collected
16 from drug manufacturers by such entity on the
17 total amount of copayment assistance dollars
18 paid, or copayment cards applied, that were
19 funded by the drug manufacturer with respect
20 to the participants and beneficiaries in such
21 plan;

22 “(B) a list of each drug covered by such
23 plan or entity providing pharmacy benefit man-
24 agement services that was billed during the re-

1 porting period, including, with respect to each
2 such drug during the reporting period—

3 “(i) the brand name, generic or non-
4 proprietary name, and National Drug
5 Code;

6 “(ii) the number of participants and
7 beneficiaries for whom the drug was billed
8 during the reporting period, the total num-
9 ber of prescription claims for the drug (in-
10 cluding original prescriptions and refills),
11 and the total number of dosage units of
12 the drug dispensed across the reporting pe-
13 riod;

14 “(iii) for each claim or dosage unit de-
15 scribed in clause (ii), the type of dis-
16 pensing channel used, such as retail, mail
17 order, or specialty pharmacy;

18 “(iv) the wholesale acquisition cost,
19 listed as cost per days supply, cost per dos-
20 age unit, and cost per typical course of
21 treatment (as applicable);

22 “(v) the total out-of-pocket spending
23 by participants and beneficiaries on such
24 drug after application of any benefits
25 under the plan, including participant and

1 beneficiary spending through copayments,
2 coinsurance, and deductibles, but not in-
3 cluding any amounts spent by participants
4 and beneficiaries on drugs not covered
5 under the plan or for which no claim is
6 submitted to the plan; and

7 “(vi) for any drug for which gross
8 spending by the plan exceeded \$10,000
9 and that is one of the 50 prescription
10 drugs for which the group health plan
11 spent the most on prescription drug bene-
12 fits during the reporting period—

13 “(I) a list of all other drugs in
14 the same therapeutic class, including
15 brand name drugs and biological
16 products and generic drugs or bio-
17 similar biological products that are in
18 the same therapeutic class as such
19 drug; and

20 “(II) if applicable, the rationale
21 for preferred formulary placement of
22 such drug in that therapeutic class,
23 selected from a list of standard ra-
24 tionales established by the Secretary;

1 “(C) a list of each therapeutic class of
2 drugs that were dispensed under the health
3 plan during the reporting period, and, with re-
4 spect to each such therapeutic class of drugs,
5 during the reporting period—

6 “(i) total gross spending by the plan,
7 before rebates, fees, alternative discounts,
8 or other remuneration;

9 “(ii) the number of participants and
10 beneficiaries who filled a prescription for a
11 drug in that class;

12 “(iii) if applicable to that class, a de-
13 scription of the formulary tiers and utiliza-
14 tion management mechanisms (such as
15 prior authorization or step therapy) em-
16 ployed for drugs in that class;

17 “(iv) the total out-of-pocket spending
18 by participants and beneficiaries, including
19 participant and beneficiary spending
20 through copayments, coinsurance, and
21 deductibles; and

22 “(v) for each therapeutic class under
23 which 3 or more drugs are included on the
24 formulary of such plan—

1 “(I) the amount received, or ex-
2 pected to be received, by such entity,
3 from an applicable entity, in rebates,
4 fees, alternative discounts, or other
5 remuneration that—

6 “(aa) has been paid, or will
7 be paid, by such an applicable
8 entity for claims incurred during
9 the reporting period; or

10 “(bb) is related to utilization
11 of drugs or drug spending;

12 “(II) the total net spending by
13 the health plan on that class of drugs;
14 and

15 “(III) the net price per typical
16 course of treatment or 30-day supply
17 incurred by the health plan and its
18 participants and beneficiaries, after
19 rebates, fees, alternative discounts, or
20 other remuneration provided by an
21 applicable entity, for drugs dispensed
22 within such therapeutic class during
23 the reporting period;

24 “(D) total gross spending on prescription
25 drugs by the plan during the reporting period,

1 before rebates, fees, alternative discounts, or
2 other remuneration provided by an applicable
3 entity;

4 “(E) the total amount received, or ex-
5 pected to be received, by the health plan, from
6 an applicable entity, in rebates, fees, alternative
7 discounts, and other remuneration received
8 from any such entities, related to utilization of
9 drug or drug spending under that health plan
10 during the reporting period;

11 “(F) the total net spending on prescription
12 drugs by the health plan during the reporting
13 period;

14 “(G) amounts paid directly or indirectly in
15 rebates, fees, or any other type of compensation
16 (as defined in section 408(b)(2)(B)(ii)(dd)(AA)
17 of the Employee Retirement Income Security
18 Act of 1974 (29 U.S.C.
19 1108(b)(2)(B)(ii)(dd)(A))) to brokers, consult-
20 ants, advisors, or any other individual or firm
21 who referred the group health plan’s business to
22 the pharmacy benefit manager; and

23 “(H) a summary document that includes
24 such information described in subparagraphs
25 (A) through (G) as the Secretary determines

1 useful for plan sponsors for purposes of select-
2 ing pharmacy benefit management services,
3 such as an estimated net price to plan sponsor
4 and participant or beneficiary, a cost per claim,
5 the fee structure or reimbursement model, and
6 estimated cost per participant or beneficiary.

7 “(2) SUPPLEMENTARY REPORTING FOR INTRA-
8 COMPANY PRESCRIPTION DRUG TRANSACTIONS.—

9 “(A) IN GENERAL.—An entity providing
10 pharmacy benefit management services under a
11 covered group health plan shall submit, to-
12 gether with the report under paragraph (1), a
13 supplementary report every 6 months to the
14 plan sponsor that includes—

15 “(i) an explanation of any benefit de-
16 sign parameters that encourage or require
17 participants and beneficiaries in the plan
18 to fill prescriptions at mail order, specialty,
19 or retail pharmacies that are wholly or
20 partially-owned by that entity providing
21 pharmacy benefit management services
22 under such plan, including mandatory mail
23 and specialty home delivery programs, re-
24 tail and mail auto-refill programs, and co-
25 payment incentives funded by an entity

1 providing pharmacy benefit management
2 services;

3 “(ii) the percentage of total prescrip-
4 tions charged to the plan or participants
5 and beneficiaries in the plan, that were
6 dispensed by mail order, specialty, or retail
7 pharmacies that are wholly or partially-
8 owned by the entity providing pharmacy
9 benefit management services; and

10 “(iii) a list of all drugs dispensed by
11 such wholly or partially-owned pharmacy
12 and charged to the plan, or participants
13 and beneficiaries of the plan, during the
14 applicable quarter, and, with respect to
15 each drug—

16 “(I) the amounts charged, per
17 dosage unit, per course of treatment,
18 per 30-day supply, and per 90-day
19 supply, with respect to participants
20 and beneficiaries in the plan, includ-
21 ing amounts charged to the plan and
22 amounts charged to the participants
23 and beneficiaries;

24 “(II) the median amount charged
25 to the plan, per dosage unit, per

1 course of treatment, per 30-day sup-
2 ply, and per 90-day supply, including
3 amounts paid by the participants and
4 beneficiaries, when the same drug is
5 dispensed by other pharmacies that
6 are not wholly or partially-owned by
7 the entity and that are included in the
8 pharmacy network of that plan;

9 “(III) the interquartile range of
10 the costs, per dosage unit, per course
11 of treatment, per 30-day supply, and
12 per 90-day supply, including amounts
13 paid by the participants and bene-
14 ficiaries, when the same drug is dis-
15 pensed by other pharmacies that are
16 not wholly or partially-owned by the
17 entity and that are included in the
18 pharmacy network of that plan;

19 “(IV) the lowest cost, per dosage
20 unit, per course of treatment, per 30-
21 day supply, and per 90-day supply,
22 for such drug, including amounts
23 charged to the plan and participants
24 and beneficiaries, that is available

1 from any pharmacy included in the
2 network of the plan;

3 “(V) the net acquisition cost per
4 dosage unit and for a 30 day-supply,
5 and the acquisition cost per typical
6 course of treatment, if the drug is
7 subject to a maximum price discount;
8 and

9 “(VI) other information with re-
10 spect to the cost of the drug, as deter-
11 mined by the Secretary, such as aver-
12 age sales price, wholesale acquisition
13 cost, and national average drug acqui-
14 sition cost per dosage unit, per typical
15 course of treatment, or per 30-day
16 supply, for such drug, including
17 amounts charged to the plan and par-
18 ticipants and beneficiaries among all
19 pharmacies included in the network of
20 the plan.

21 “(B) PLANS OFFERED BY SMALL EMPLOY-
22 ERS.—An entity providing pharmacy benefit
23 management services under a group health plan
24 that is not a covered group health plan that
25 conducts transactions with a wholly or partially-

1 owned pharmacy shall submit, together with the
2 report under paragraph (1), a supplementary
3 report every 6 months to the plan sponsor that
4 includes the information described in clauses (i)
5 and (ii) of subparagraph (A).

6 “(3) PRIVACY REQUIREMENTS.—

7 “(A) RELATIONSHIP TO HIPAA REGULA-
8 TIONS.—Nothing in this section shall be con-
9 strued to modify the requirements for the cre-
10 ation, receipt, maintenance, or transmission of
11 protected health information under the privacy,
12 security, breach notification, and enforcement
13 regulations in parts 160 and 164 of title 45,
14 Code of Federal Regulations (or successor regu-
15 lations).

16 “(B) REQUIREMENT.—A report submitted
17 under paragraph (1) or (2) shall contain only
18 summary health information, as defined in sec-
19 tion 164.504(a) of title 45, Code of Federal
20 Regulations (or successor regulations).

21 “(C) CLARIFICATION REGARDING CERTAIN
22 DISCLOSURES OF INFORMATION.—

23 “(i) REASONABLE RESTRICTIONS.—
24 Nothing in this section prevents an entity
25 providing pharmacy benefit management

1 services on behalf of a group health plan
2 from placing reasonable restrictions on the
3 public disclosure of the information con-
4 tained in a report under paragraph (1) or
5 (2).

6 “(ii) LIMITATIONS.—An entity pro-
7 viding pharmacy benefit management serv-
8 ices on behalf of a group health plan or
9 group health insurance coverage may not
10 restrict disclosure of such reports to the
11 Department of Health and Human Serv-
12 ices, the Department of Labor, the Depart-
13 ment of the Treasury, or any other Federal
14 agency responsible for enforcement activi-
15 ties under this section for purposes of en-
16 forcement under this section or other ap-
17 plicable law, or to the Comptroller General
18 of the United States in accordance with
19 paragraph (6).

20 “(4) USE AND DISCLOSURE BY PLAN SPON-
21 SORS.—

22 “(A) PROHIBITION.—A plan sponsor may
23 not—

24 “(i) fail or refuse to hire, or dis-
25 charge, any employee, or otherwise dis-

1 criminate against any employee with re-
2 spect to the compensation, terms, condi-
3 tions, or privileges of employment of the
4 employee, because of information sub-
5 mitted under paragraph (1) or (2) attrib-
6 uted to the employee or a dependent of the
7 employee; or

8 “(ii) limit, segregate, or classify the
9 employees of the employer in any way that
10 would deprive or tend to deprive any em-
11 ployee of employment opportunities or oth-
12 erwise adversely affect the status of the
13 employee as an employee, because of infor-
14 mation submitted under paragraph (1) or
15 (2) attributed to the employee or a depend-
16 ent of the employee.

17 “(B) DISCLOSURE AND REDISCLOSURE.—

18 A plan sponsor shall not disclose the informa-
19 tion received under paragraph (1) or (2) ex-
20 cept—

21 “(i) to an occupational or other health
22 researcher if the research is conducted in
23 compliance with the regulations and pro-
24 tections provided for under part 46 of title

1 45, Code of Federal Regulations (or suc-
2 cessor regulations);

3 “(ii) in response to an order of a
4 court, except that the plan sponsor may
5 disclose only the information expressly au-
6 thorized by such order;

7 “(iii) to the Department of Health
8 and Human Services, the Department of
9 Labor, the Department of the Treasury, or
10 other Federal agency responsible for en-
11 forcement activities under this section; or

12 “(iv) to a contractor or agent for pur-
13 poses of health plan administration, if such
14 contractor or agent agrees, in writing, to
15 abide by the same use and disclosure re-
16 strictions as the plan sponsor.

17 “(C) RELATIONSHIP TO HIPAA REGULA-
18 TIONS.—With respect to the regulations pro-
19 mulgated by the Secretary of Health and
20 Human Services under part C of title XI of the
21 Social Security Act (42 U.S.C. 1320d et seq.)
22 and section 264 of the Health Insurance Port-
23 ability and Accountability Act of 1996 (42
24 U.S.C. 1320d–2), subparagraph (B) does not
25 prohibit a covered entity (as defined for pur-

1 poses of such regulations) from any use or dis-
2 closure of health information that is authorized
3 for the covered entity under such regulations.
4 The previous sentence does not affect the au-
5 thority of such Secretary to modify such regula-
6 tions.

7 “(D) ENFORCEMENT.—

8 “(i) IN GENERAL.—The powers, pro-
9 cedures, and remedies provided in section
10 207 of the Genetic Information Non-
11 discrimination Act (42 U.S.C. 2000ff–6) to
12 a person alleging a violation of title II of
13 such Act shall be the powers, procedures,
14 and remedies this subparagraph provides
15 for any person alleging a violation of this
16 paragraph.

17 “(ii) PROHIBITION AGAINST RETALIA-
18 TION.—No person shall discriminate
19 against any individual because such indi-
20 vidual has opposed any act or practice
21 made unlawful by this paragraph or be-
22 cause such individual made a charge, testi-
23 fied, assisted, or participated in any man-
24 ner in an investigation, proceeding, or
25 hearing under this paragraph. The rem-

1 edies and procedures otherwise provided
2 for under this subparagraph shall be avail-
3 able to aggrieved individuals with respect
4 to violations of this clause.

5 “(5) REPORTING WITH RESPECT TO GROUP
6 HEALTH PLANS OFFERED BY SMALL EMPLOYERS.—
7 For plan years beginning on or after January 1,
8 2025, not less frequently than annually, an entity
9 providing pharmacy benefit management services on
10 behalf of a group health plan that is not a covered
11 group health plan shall submit to the plan sponsor
12 of such group health plan a report in accordance
13 with this paragraph, and make such report available
14 to the plan sponsor in a machine-readable format.
15 Each such report shall include, with respect to the
16 applicable group health plan, the information de-
17 scribed in subparagraphs (A), (D), (E), (F), (G),
18 and (H) of paragraph (1).

19 “(6) SUBMISSIONS TO GAO.—An entity pro-
20 viding pharmacy benefit management services on be-
21 half of a group health plan shall submit to the
22 Comptroller General of the United States each of
23 the first 2 reports submitted to a plan sponsor under
24 paragraph (1) or (5) with respect to such plan, and
25 other such reports as requested, in accordance with

1 the privacy requirements under paragraph (3), and
2 such other information that the Comptroller General
3 determines necessary to carry out the study under
4 section 2(f) of the Pharmacy Benefit Manager Re-
5 form Act.

6 “(7) STANDARD FORMATS.—

7 “(A) IN GENERAL.—Not later than June
8 1, 2024, the Secretary, the Secretary of Health
9 and Human Services, and the Secretary of
10 Labor shall specify, through rulemaking, stand-
11 ard formats for health insurance issuers and
12 entities providing pharmacy benefit manage-
13 ment services to submit reports required under
14 this subsection.

15 “(B) LIMITED FORM OF REPORT.—The
16 Secretary, the Secretary of Health and Human
17 Services, and the Secretary of Labor shall de-
18 fine through rulemaking a limited form of the
19 reports under paragraphs (1) and (2) required
20 to be submitted to plan sponsors who also are
21 drug manufacturers, drug wholesalers, entities
22 providing pharmacy benefit management serv-
23 ices, or other direct participants in the drug
24 supply chain, in order to prevent anti-competi-
25 tive behavior.

1 “(c) LIMITATIONS ON SPREAD PRICING.—

2 “(1) IN GENERAL.—A group health plan shall
3 not charge participants and beneficiaries, and an en-
4 tity providing pharmacy benefit management serv-
5 ices under such a plan shall not charge the plan or
6 participants and beneficiaries, a price for a prescrip-
7 tion drug that exceeds the price paid to the phar-
8 macy for such drug, excluding penalties paid by the
9 pharmacy (as described in paragraph (2)) to such
10 plan or entity.

11 “(2) RULE OF CONSTRUCTION.—For purposes
12 of paragraph (1), penalties paid by pharmacies in-
13 clude only the following:

14 “(A) A penalty paid if an original claim for
15 a prescription drug was submitted fraudulently
16 by the pharmacy to the plan or entity.

17 “(B) A penalty paid if the original claim
18 payment made by the plan, issuer, or entity to
19 the pharmacy was inconsistent with the reim-
20 bursment terms in any contract between the
21 pharmacy and the plan or entity.

22 “(C) A penalty paid if the pharmacist serv-
23 ices billed to the plan or entity were not ren-
24 dered by the pharmacy.

25 “(d) FULL REBATE PASS-THROUGH TO PLAN.—

1 “(1) IN GENERAL.—For plan years beginning
2 on or after January 1, 2025, a third-party adminis-
3 trator of a group health plan or an entity providing
4 pharmacy benefit management services under such
5 health plan shall—

6 “(A) remit 100 percent of rebates, fees, al-
7 ternative discounts, and other remuneration re-
8 ceived from any applicable entity that are re-
9 lated to utilization of drugs under such health
10 plan, to the group health plan; and

11 “(B) ensure that any contract entered into
12 by such third-party administrator or entity pro-
13 viding pharmacy benefit management services
14 with an applicable entity remit 100 percent of
15 rebates, fees, alternative discounts, and other
16 remuneration received to the third-party admin-
17 istrator or entity providing pharmacy benefit
18 management services.

19 “(2) FORM AND MANNER OF REMITTANCE.—
20 Such rebates, fees, alternative discounts, and other
21 remuneration shall be—

22 “(A) remitted to the group health plan in
23 a timely fashion after the period for which such
24 rebates, fees, alternative discounts, or other re-

1 muneration is calculated, and in no case later
2 than 90 days after the end of such period;

3 “(B) fully disclosed and enumerated to the
4 group health plan sponsor, as described in para-
5 graphs (1) and (4) of subsection (b);

6 “(C) available for audit by the plan spon-
7 sor, or a third-party designated by a plan spon-
8 sor not less than once per plan year; and

9 “(D) returned to the issuer or entity pro-
10 viding pharmaceutical benefit management
11 services by the group health plan if audits by
12 such entity indicate that the amounts received
13 are incorrect after such amounts have been paid
14 to the group health plan.

15 “(3) AUDIT OF REBATE CONTRACTS.—A third-
16 party administrator of a group health plan or an en-
17 tity providing pharmacy benefit management serv-
18 ices under such health plan shall make rebate con-
19 tracts with rebate aggregators or drug manufactur-
20 ers available for audit by such plan sponsor or des-
21 ignated third-party, subject to confidentiality agree-
22 ments to prevent re-disclosure of such contracts.

23 “(4) AUDITORS.—The applicable plan sponsor
24 may select an auditor for purposes of carrying out
25 audits under paragraphs (2)(C) and (3).

1 “(5) RULE OF CONSTRUCTION.—Nothing in
2 this subsection shall be construed to prohibit pay-
3 ments to entities offering pharmacy benefit manage-
4 ment services for bona fide services using a fee
5 structure not contemplated by this subsection, pro-
6 vided that such fees are transparent to group health
7 plans.

8 “(e) ENFORCEMENT.—

9 “(1) IN GENERAL.—The Secretary, in consulta-
10 tion with the Secretary of Labor and the Secretary
11 of Health and Human Services, shall enforce this
12 section.

13 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
14 TION.—A health insurance issuer or an entity pro-
15 viding pharmacy benefit management services that
16 violates subsection (a) or fails to provide information
17 required under subsection (b); a group health plan
18 or entity providing pharmacy benefit management
19 services that violates subsection (c); or a third-party
20 administrator of a group health plan or an entity
21 providing pharmacy benefit management services
22 that violates subsection (d) shall be subject to a civil
23 monetary penalty in the amount of \$10,000 for each
24 day during which such violation continues or such
25 information is not disclosed or reported.

1 “(3) FALSE INFORMATION.—An entity pro-
2 viding pharmacy benefit management services, or
3 drug manufacturer that knowingly provides false in-
4 formation under this section shall be subject to a
5 civil money penalty in an amount not to exceed
6 \$100,000 for each item of false information. Such
7 civil money penalty shall be in addition to other pen-
8 alties as may be prescribed by law.

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

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

23 “(f) RULE OF CONSTRUCTION.—Nothing in this sec-
24 tion shall be construed to permit a group health plan or
25 other entity to restrict disclosure to, or otherwise limit the

1 access of, the Department of the Treasury to a report de-
2 scribed in subsection (b)(1) or information related to com-
3 pliance with subsection (a) by such plan or entity.

4 “(g) DEFINITIONS.—In this section—

5 “(1) the term ‘applicable entity’ means—

6 “(A) a drug manufacturer, distributor,
7 wholesaler, rebate aggregator (or other pur-
8 chasing entity designed to aggregate rebates),
9 group purchasing organization, or associated
10 third party;

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

17 “(C) such other entity as the Secretary,
18 the Secretary of Health and Human Services,
19 and the Secretary of Labor may specify through
20 rulemaking;

21 “(2) the term ‘covered group health insurance
22 coverage’ means health insurance coverage offered in
23 connection with a group health plan maintained by
24 a large employer;

1 “(3) the term ‘covered group health plan’
2 means a group health plan maintained by a large
3 employer;

4 “(4) the term ‘gross spending’, with respect to
5 prescription drug benefits under a group health plan
6 or health insurance coverage, means the amount
7 spent by a group health plan or health insurance
8 issuer on prescription drug benefits, calculated be-
9 fore the application of manufacturer rebates, fees,
10 alternative discounts, or other remuneration;

11 “(5) the term ‘large employer’ means, in con-
12 nection with a group health plan with respect to a
13 calendar year and a plan year, an employer who em-
14 ployed an average of at least 50 employees on busi-
15 ness days during the preceding calendar year and
16 who employs at least 1 employee on the first day of
17 the plan year;

18 “(6) the term ‘net spending’, with respect to
19 prescription drug benefits under a group health plan
20 or health insurance coverage, means the amount
21 spent by a group health plan or health insurance
22 issuer on prescription drug benefits, calculated after
23 the application of manufacturer rebates, fees, alter-
24 native discounts, or other remuneration;

1 (1) For purposes of carrying out the amend-
2 ments made by subsection (a), there are appro-
3 priated to the Centers for Medicare & Medicaid
4 Services, out of amounts in the Treasury not other-
5 wise appropriated, \$80,000,000 for fiscal year 2024.

6 (2) For purposes of carrying out the amend-
7 ments made by subsection (b), there are appro-
8 priated to the Department of Labor, out of amounts
9 in the Treasury not otherwise appropriated,
10 \$43,750,000 for fiscal year 2024.

11 (e) ASPE STUDY.—The Assistant Secretary for
12 Planning and Evaluation of the Department of Health and
13 Human Services shall conduct or commission a study on
14 how the United States health care market would be im-
15 pacted by potential regulatory changes disallowing manu-
16 facturer rebates in the manner and to the extent allowed
17 on the date of enactment of this Act, with a focus on the
18 impact to stakeholders in the commercial insurance mar-
19 ket, and, not later than 1 year after the date of enactment
20 of this Act, submit a report to Congress on the results
21 of such study. Such study and report shall consider the
22 following:

23 (1) The impact on the impact of making no
24 such regulatory changes, as well as potential behav-
25 ioral changes by plan sponsors, members, and phar-

1 maceutical manufacturers, such as tighter
2 formularies, changes to price concessions, changes in
3 utilization, if such regulatory changes are made.

4 (2) The mechanics needed in the pharma-
5 ceutical supply chain (whether existing or not) to
6 move a manufacturer rebate to the point of sale.

7 (3) The feasibility of a partial point-of-sale
8 manufacturer rebate versus a full point-of-sale man-
9 ufacturer rebate.

10 (4) The impact on patient out-of-pocket costs,
11 premiums, and other cost-sharing.

12 (5) Possible behavioral changes by other third
13 parties in the pharmaceutical supply chain including
14 drug manufacturer, distributor, wholesaler, rebate
15 aggregators, pharmacy services administrative orga-
16 nizations, or group purchasing organizations.

17 (6) Behavioral changes between entities that
18 contract with pharmaceutical manufacturers and
19 pharmaceutical supply chain.

20 (7) Alternative price negotiation mechanisms,
21 including the impact of the Act of June 19, 1936
22 (commonly known as the “Robinson–Patman Act”;
23 49 Stat. 1526, chapter 592; 15 U.S.C. 13a et seq.),
24 and the amendments made by that Act, on drug
25 pricing negotiations.

1 (8) The impact on pharmacies, including phar-
2 macy rebates, pharmacy fees, and dispensing chan-
3 nels.

4 (f) GAO STUDY.—

5 (1) IN GENERAL.—Not later than January 1,
6 2029, the Comptroller General of the United States
7 shall report to Congress on—

8 (A) pharmacy networks of group health
9 plans, health insurance issuers, and entities
10 providing pharmacy benefit management serv-
11 ices under such group health plan or group or
12 individual health insurance coverage, including
13 networks that have pharmacies that are under
14 common ownership (in whole or part) with
15 group health plans, health insurance issuers, or
16 entities providing pharmacy benefit manage-
17 ment services or pharmacy benefit administra-
18 tive services under group health plan or group
19 or individual health insurance coverage;

20 (B) as it relates to pharmacy networks
21 that include pharmacies under common owner-
22 ship described in subparagraph (A)—

23 (i) whether such networks are de-
24 signed to encourage participants and bene-
25 ficiaries of a plan or coverage to use such

1 pharmacies over other network pharmacies
2 for specific services or drugs, and if so, the
3 reasons the networks give for encouraging
4 use of such pharmacies; and

5 (ii) whether such pharmacies are used
6 by participants and beneficiaries dispropor-
7 tionately more in the aggregate or for spe-
8 cific services or drugs compared to other
9 network pharmacies;

10 (C) whether group health plans and health
11 insurance issuers offering group or individual
12 health insurance coverage have options to elect
13 different network pricing arrangements in the
14 marketplace with entities that provide phar-
15 macy benefit management services, the preva-
16 lence of electing such different network pricing
17 arrangements;

18 (D) pharmacy network design parameters
19 that encourage participants and beneficiaries in
20 the plan or coverage to fill prescriptions at mail
21 order, specialty, or retail pharmacies that are
22 wholly or partially-owned by that issuer or enti-
23 ty; and

24 (E) the degree to which mail order, spe-
25 cialty, or retail pharmacies that dispense pre-

1 description drugs to participants and beneficiaries
2 in a group health plan or health insurance cov-
3 erage that are under common ownership (in
4 whole or part) with group health plans, health
5 insurance issuers, or entities providing phar-
6 macy benefit management services or pharmacy
7 benefit administrative services under group
8 health plan or group or individual health insur-
9 ance coverage receive reimbursement that is
10 greater than the median price charged to the
11 group health plan or health insurance issuer
12 when the same drug is dispensed to participants
13 and beneficiaries in the plan or coverage by
14 other pharmacies included in the pharmacy net-
15 work of that plan, issuer, or entity that are not
16 wholly or partially owned by the health insur-
17 ance issuer or entity providing pharmacy ben-
18 efit management services.

19 (2) REQUIREMENT.—In carrying out paragraph
20 (1), the Comptroller General of the United States
21 shall not disclose—

22 (A) information that would allow for iden-
23 tification of a specific individual, plan sponsor,
24 health insurance issuer, plan, or entity pro-

1 viding pharmacy benefit management services;
2 or

3 (B) commercial or financial information
4 that is privileged or confidential.

5 (3) DEFINITIONS.—In this subsection, the
6 terms “group health plan”, “health insurance cov-
7 erage”, and “health insurance issuer” have the
8 meanings given such terms in section 2791 of the
9 Public Health Service Act (42 U.S.C. 300gg–91).

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