

118TH CONGRESS
1ST SESSION

H. R. 4846

To amend the Internal Revenue Code of 1986, title XXVII of the Public Health Service Act, and the Employee Retirement Income Security Act of 1974 to provide for oversight of pharmacy benefit manager services.

IN THE HOUSE OF REPRESENTATIVES

JULY 25, 2023

Mr. ARRINGTON introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Internal Revenue Code of 1986, title XXVII of the Public Health Service Act, and the Employee Retirement Income Security Act of 1974 to provide for oversight of pharmacy benefit manager services.

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 “Better Deals and
5 Lower Prices Act”.

1 **SEC. 2. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
2 **SERVICES.**

3 (a) IRC.—

4 (1) IN GENERAL.—Subchapter B of chapter
5 100 of the Internal Revenue Code of 1986 is amend-
6 ed by adding at the end the following:

7 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFITS MAN-**
8 **AGER SERVICES.**

9 “(a) IN GENERAL.—For plan years beginning on or
10 after the date that is 3 years after the date of enactment
11 of this section, a group health plan, or an entity or sub-
12 sidiary providing pharmacy benefits management services
13 on behalf of such a plan, shall not enter into a contract
14 with a drug manufacturer, distributor, wholesaler, subcon-
15 tractor, rebate aggregator, or any associated third party
16 that limits the disclosure of information to plan sponsors
17 in such a manner that prevents the plan, or an entity or
18 subsidiary providing pharmacy benefits management serv-
19 ices on behalf of a plan, from making the report described
20 in subsection (b).

21 “(b) ANNUAL REPORT.—

22 “(1) IN GENERAL.—With respect to plan years
23 beginning on or after the date that is 3 years after
24 the date of enactment of this section, for each such
25 plan year, a group health plan, or an entity pro-
26 viding pharmacy benefits management services on

1 behalf of such a plan, shall submit to the plan spon-
2 sor (as defined in section 3(16)(B) of the Employee
3 Retirement Income Security Act of 1974) of such
4 plan a report in a machine-readable format. Each
5 such report shall include, with respect to such plan
6 provided for such plan year—

7 “(A) to the extent feasible, information col-
8 lected from drug manufacturers (or an entity
9 administering copay assistance on behalf of
10 such manufacturers) by such plan on the total
11 amount of copayment assistance dollars paid, or
12 copayment cards applied, that were funded by
13 the drug manufacturer with respect to the par-
14 ticipants and beneficiaries in such plan;

15 “(B) a list of each drug covered by such
16 plan that was dispensed during the plan year,
17 including, with respect to each such drug dur-
18 ing such plan year—

19 “(i) the brand name, chemical entity,
20 and National Drug Code;

21 “(ii) the number of participants and
22 beneficiaries for whom the drug was dis-
23 pensed during the plan year, the total
24 number of prescription claims for the drug
25 (including original prescriptions and re-

1 fills), and the total number of dosage units
2 of the drug dispensed across the plan year,
3 disaggregated by dispensing channel (such
4 as retail, mail order, or specialty phar-
5 macy);

6 “(iii) the wholesale acquisition cost,
7 listed as cost per days supply and cost per
8 pill, or in the case of a drug in another
9 form, per dosage unit;

10 “(iv) the total out-of-pocket spending
11 by participants and beneficiaries on such
12 drug, including participant and beneficiary
13 spending through copayments, coinsurance,
14 and deductibles;

15 “(v) for any drug for which gross
16 spending of the group health plan exceeded
17 \$10,000 during the plan year—

18 “(I) a list of all other drugs in
19 the same therapeutic category or
20 class, including brand name drugs
21 and biological products and generic
22 drugs or biosimilar biological products
23 that are in the same therapeutic cat-
24 egory or class as such drug; and

1 “(II) the rationale for the for-
2 mulary placement of such drug in that
3 therapeutic category or class, if appli-
4 cable;

5 “(vi) the amount received, or expected
6 to be received, from drug manufacturers in
7 rebates, fees, alternative discounts, or
8 other remuneration for claims incurred for
9 such drug during the plan year;

10 “(vii) the total net spending, after de-
11 ducting rebates, price concessions, alter-
12 native discounts or other remuneration
13 from drug manufacturers, by the health
14 plan on such drug; and

15 “(viii) the net price per course of
16 treatment or single fill, such as a 30-day
17 supply or 90-day supply, incurred by the
18 health plan and its participants and bene-
19 ficiaries after manufacturer rebates, fees,
20 and other remuneration for such drug dis-
21 pensed during the plan year;

22 “(C) a list of each therapeutic category or
23 class of drugs that were dispensed under the
24 health plan during the plan year, and, with re-

1 spect to each such therapeutic category or class
2 of drugs, during the plan year—

3 “(i) total gross spending by the plan,
4 before manufacturer rebates, fees, or other
5 manufacturer remuneration;

6 “(ii) the number of participants and
7 beneficiaries who were dispensed a drug
8 covered by such plan in that category or
9 class, broken down by each such drug
10 (identified by National Drug Code);

11 “(iii) if applicable to that category or
12 class, a description of the formulary tiers
13 and utilization management (such as prior
14 authorization or step therapy) employed
15 for drugs in that category or class; and

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

21 “(D) total gross spending on prescription
22 drugs by the plan during the plan year, before
23 rebates and other manufacturer fees or remu-
24 neration;

1 “(E) total amount received, or expected to
2 be received, by the health plan in drug manu-
3 facturer rebates, fees, alternative discounts, and
4 all other remuneration received from the manu-
5 facturer or any third party, other than the plan
6 sponsor, related to utilization of drug or drug
7 spending under that health plan during the
8 plan year;

9 “(F) the total net spending on prescription
10 drugs by the health plan during the plan year;
11 and

12 “(G) amounts paid directly or indirectly in
13 rebates, fees, or any other type of remuneration
14 to brokers, consultants, advisors, or any other
15 individual or firm for the referral of the group
16 health plan’s business to the pharmacy benefits
17 manager.

18 “(2) PRIVACY REQUIREMENTS.—Entities pro-
19 viding pharmacy benefits management services on
20 behalf of a group health plan shall provide informa-
21 tion under paragraph (1) in a manner consistent
22 with the privacy, security, and breach notification
23 regulations promulgated under section 264(c) of the
24 Health Insurance Portability and Accountability Act
25 of 1996, and shall restrict the use and disclosure of

1 such information according to such privacy regula-
2 tions.

3 “(3) DISCLOSURE AND REDISCLOSURE.—

4 “(A) LIMITATION TO BUSINESS ASSOCI-
5 ATES.—A group health plan receiving a report
6 under paragraph (1) may disclose such informa-
7 tion only to business associates of such plan as
8 defined in section 160.103 of title 45, Code of
9 Federal Regulations (or successor regulations).

10 “(B) CLARIFICATION REGARDING PUBLIC
11 DISCLOSURE OF INFORMATION.—Nothing in
12 this section prevents an entity providing phar-
13 macy benefits management services on behalf of
14 a group health plan from placing reasonable re-
15 strictions on the public disclosure of the infor-
16 mation contained in a report described in para-
17 graph (1), except that such entity may not re-
18 strict disclosure of such report to the Depart-
19 ment of Health and Human Services, the De-
20 partment of Labor, the Department of the
21 Treasury, the Comptroller General of the
22 United States, or applicable State agencies.

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

1 required of plan sponsors who are drug manu-
2 facturers, drug wholesalers, or other direct par-
3 ticipants in the drug supply chain, in order to
4 prevent anti-competitive behavior.

5 “(4) REPORT TO GAO.—A group health plan, or
6 an entity providing pharmacy benefits management
7 services on behalf of a group health plan, shall sub-
8 mit to the Comptroller General of the United States
9 each of the first 4 reports submitted to a plan spon-
10 sor under paragraph (1) with respect to such plan,
11 and other such reports as requested, in accordance
12 with the privacy requirements under paragraph (2),
13 the disclosure and redisclosure standards under
14 paragraph (3), the standards specified pursuant to
15 paragraph (5), and such other information that the
16 Comptroller General determines necessary to carry
17 out the study under section 2(d) of the Better Deals
18 and Lower Prices Act.

19 “(5) STANDARD FORMAT.—Not later than 18
20 months after the date of enactment of this section,
21 the Secretary shall specify through rulemaking
22 standards for entities required to submit reports
23 under paragraph (4) to submit such reports in a
24 standard format.

1 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
2 tion shall be construed to permit a group health plan or
3 other entity to restrict disclosure to, or otherwise limit the
4 access of, the Secretary of the Treasury to a report de-
5 scribed in subsection (b)(1) or information related to com-
6 pliance with subsection (a) or (b) by such plan or other
7 entity subject to such subsections.

8 “(d) DEFINITION.—In this section, the term ‘whole-
9 sale acquisition cost’ has the meaning given such term in
10 section 1847A(c)(6)(B) of the Social Security Act.”.

11 (2) CLERICAL AMENDMENT.—The table of sec-
12 tions for subchapter B of chapter 100 of the Inter-
13 nal Revenue Code of 1986 is amended by adding at
14 the end the following new item:

“Sec. 9826. Oversight of pharmacy benefits manager services.”.

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

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

19 **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFITS MAN-
20 AGER SERVICES.**

21 “(a) IN GENERAL.—For plan years beginning on or
22 after the date that is 3 years after the date of enactment
23 of this section, a group health plan or health insurance
24 issuer offering group health insurance coverage, or an en-
25 tity or subsidiary providing pharmacy benefits manage-

1 ment services on behalf of such a plan or issuer, shall not
2 enter into a contract with a drug manufacturer, dis-
3 tributor, wholesaler, subcontractor, rebate aggregator, or
4 any associated third party that limits the disclosure of in-
5 formation to plan sponsors in such a manner that prevents
6 the plan or issuer, or an entity or subsidiary providing
7 pharmacy benefits management services on behalf of a
8 plan or issuer, from making the report described in sub-
9 section (b).

10 “(b) ANNUAL REPORT.—

11 “(1) IN GENERAL.—With respect to plan years
12 beginning on or after the date that is 3 years after
13 the date of enactment of this section, for each such
14 plan year, a group health plan or health insurance
15 issuer offering group health insurance coverage, or
16 an entity providing pharmacy benefits management
17 services on behalf of such a plan or an issuer, shall
18 submit to the plan sponsor (as defined in section
19 3(16)(B) of the Employee Retirement Income Secu-
20 rity Act of 1974) of such plan or coverage a report
21 in a machine-readable format. Each such report
22 shall include, with respect to such plan or coverage
23 provided for such plan year—

24 “(A) to the extent feasible, information col-
25 lected from drug manufacturers (or an entity

1 administering copay assistance on behalf of
2 such manufacturers) by such plan or issuer on
3 the total amount of copayment assistance dol-
4 lars paid, or copayment cards applied, that were
5 funded by the drug manufacturer with respect
6 to the participants, beneficiaries, and enrollees
7 in such plan or coverage;

8 “(B) a list of each drug covered by such
9 plan or coverage that was dispensed during the
10 plan year, including, with respect to each such
11 drug during such plan year—

12 “(i) the brand name, chemical entity,
13 and National Drug Code;

14 “(ii) the number of participants, bene-
15 ficiaries, and enrollees for whom the drug
16 was dispensed during the plan year, the
17 total number of prescription claims for the
18 drug (including original prescriptions and
19 refills), and the total number of dosage
20 units of the drug dispensed across the plan
21 year, disaggregated by dispensing channel
22 (such as retail, mail order, or specialty
23 pharmacy);

24 “(iii) the wholesale acquisition cost,
25 listed as cost per days supply and cost per

1 pill, or in the case of a drug in another
2 form, per dosage unit;

3 “(iv) the total out-of-pocket spending
4 by participants, beneficiaries, and enrollees
5 on such drug, including participant, bene-
6 ficiary, and enrollee spending through co-
7 payments, coinsurance, and deductibles;

8 “(v) for any drug for which gross
9 spending of the group health plan or
10 health insurance coverage exceeded
11 \$10,000 during the plan year—

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

19 “(II) the rationale for the for-
20 mulary placement of such drug in that
21 therapeutic category or class, if appli-
22 cable;

23 “(vi) the amount received, or expected
24 to be received, from drug manufacturers in
25 rebates, fees, alternative discounts, or

1 other remuneration for claims incurred for
2 such drug during the plan year;

3 “(vii) the total net spending, after de-
4 ducting rebates, price concessions, alter-
5 native discounts or other remuneration
6 from drug manufacturers, by the health
7 plan or health insurance coverage on such
8 drug; and

9 “(viii) the net price per course of
10 treatment or single fill, such as a 30-day
11 supply or 90-day supply, incurred by the
12 health plan or health insurance coverage
13 and its participants, beneficiaries, and en-
14 rollees, after manufacturer rebates, fees,
15 and other remuneration for such drug dis-
16 pensed during the plan year;

17 “(C) a list of each therapeutic category or
18 class of drugs that were dispensed under the
19 health plan or health insurance coverage during
20 the plan year, and, with respect to each such
21 therapeutic category or class of drugs, during
22 the plan year—

23 “(i) total gross spending by the plan
24 or coverage, before manufacturer rebates,
25 fees, or other manufacturer remuneration;

1 “(ii) the number of participants, bene-
2 ficiaries, and enrollees who were dispensed
3 a drug covered by such plan or coverage in
4 that category or class, broken down by
5 each such drug (identified by National
6 Drug Code);

7 “(iii) if applicable to that category or
8 class, a description of the formulary tiers
9 and utilization management (such as prior
10 authorization or step therapy) employed
11 for drugs in that category or class; and

12 “(iv) the total out-of-pocket spending
13 by participants, beneficiaries, and enroll-
14 ees, including participant, beneficiary, and
15 enrollee spending through copayments, co-
16 insurance, and deductibles;

17 “(D) total gross spending on prescription
18 drugs by the plan or coverage during the plan
19 year, before rebates and other manufacturer
20 fees or remuneration;

21 “(E) total amount received, or expected to
22 be received, by the health plan or health insur-
23 ance coverage in drug manufacturer rebates,
24 fees, alternative discounts, and all other remu-
25 neration received from the manufacturer or any

1 third party, other than the plan sponsor, re-
2 lated to utilization of drug or drug spending
3 under that health plan or health insurance cov-
4 erage during the plan year;

5 “(F) the total net spending on prescription
6 drugs by the health plan or health insurance
7 coverage during the plan year; and

8 “(G) amounts paid directly or indirectly in
9 rebates, fees, or any other type of remuneration
10 to brokers, consultants, advisors, or any other
11 individual or firm for the referral of the group
12 health plan’s or health insurance issuer’s busi-
13 ness to the pharmacy benefits manager.

14 “(2) PRIVACY REQUIREMENTS.—Health insur-
15 ance issuers offering group health insurance cov-
16 erage and entities providing pharmacy benefits man-
17 agement services on behalf of a group health plan
18 shall provide information under paragraph (1) in a
19 manner consistent with the privacy, security, and
20 breach notification regulations promulgated under
21 section 264(c) of the Health Insurance Portability
22 and Accountability Act of 1996, and shall restrict
23 the use and disclosure of such information according
24 to such privacy regulations.

25 “(3) DISCLOSURE AND REDISCLOSURE.—

1 “(A) LIMITATION TO BUSINESS ASSOCI-
2 ATES.—A group health plan receiving a report
3 under paragraph (1) may disclose such informa-
4 tion only to business associates of such plan as
5 defined in section 160.103 of title 45, Code of
6 Federal Regulations (or successor regulations).

7 “(B) CLARIFICATION REGARDING PUBLIC
8 DISCLOSURE OF INFORMATION.—Nothing in
9 this section prevents a health insurance issuer
10 offering group health insurance coverage or an
11 entity providing pharmacy benefits management
12 services on behalf of a group health plan from
13 placing reasonable restrictions on the public dis-
14 closure of the information contained in a report
15 described in paragraph (1), except that such
16 issuer or entity may not restrict disclosure of
17 such report to the Department of Health and
18 Human Services, the Department of Labor, the
19 Department of the Treasury, the Comptroller
20 General of the United States, or applicable
21 State agencies.

22 “(C) LIMITED FORM OF REPORT.—The
23 Secretary shall define through rulemaking a
24 limited form of the report under paragraph (1)
25 required of plan sponsors who are drug manu-

1 facturers, drug wholesalers, or other direct par-
2 ticipants in the drug supply chain, in order to
3 prevent anti-competitive behavior.

4 “(4) REPORT TO GAO.—A group health plan or
5 health insurance issuer offering group health insur-
6 ance coverage, or an entity providing pharmacy ben-
7 efits management services on behalf of a group
8 health plan shall submit to the Comptroller General
9 of the United States each of the first 4 reports sub-
10 mitted to a plan sponsor under paragraph (1) with
11 respect to such coverage or plan, and other such re-
12 ports as requested, in accordance with the privacy
13 requirements under paragraph (2), the disclosure
14 and redisclosure standards under paragraph (3), the
15 standards specified pursuant to paragraph (5), and
16 such other information that the Comptroller General
17 determines necessary to carry out the study under
18 section 2(d) of the Better Deals and Lower Prices
19 Act.

20 “(5) STANDARD FORMAT.—Not later than 18
21 months after the date of enactment of this section,
22 the Secretary shall specify through rulemaking
23 standards for health insurance issuers and entities
24 required to submit reports under paragraph (4) to
25 submit such reports in a standard format.

1 “(c) ENFORCEMENT.—

2 “(1) IN GENERAL.—Notwithstanding section
3 2723, the Secretary, in consultation with the Sec-
4 retary of Labor and the Secretary of the Treasury,
5 shall enforce this section.

6 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
7 TION.—A health insurance issuer or an entity pro-
8 viding pharmacy benefits management services that
9 violates subsection (a) or fails to provide information
10 required under subsection (b) shall be subject to a
11 civil monetary penalty in the amount of \$10,000 for
12 each day during which such violation continues or
13 such information is not disclosed or reported.

14 “(3) FALSE INFORMATION.—A health insurance
15 issuer or entity providing pharmacy benefits man-
16 agement services that knowingly provides false infor-
17 mation under this section shall be subject to a civil
18 money penalty in an amount not to exceed \$100,000
19 for each item of false information. Such civil money
20 penalty shall be in addition to other penalties as
21 may be prescribed by law.

22 “(4) PROCEDURE.—The provisions of section
23 1128A of the Social Security Act, other than sub-
24 section (a) and (b) and the first sentence of sub-
25 section (c)(1) of such section shall apply to civil

1 monetary penalties under this subsection in the
2 same manner as such provisions apply to a penalty
3 or proceeding under section 1128A of the Social Se-
4 curity Act.

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

11 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
12 tion shall be construed to permit a health insurance issuer,
13 group health plan, or other entity to restrict disclosure to,
14 or otherwise limit the access of, the Secretary of Health
15 and Human Services to a report described in subsection
16 (b)(1) or information related to compliance with sub-
17 section (a) or (b) by such issuer, plan, or other entity sub-
18 ject to such subsections.

19 “(e) DEFINITION.—In this section, the term ‘whole-
20 sale acquisition cost’ has the meaning given such term in
21 section 1847A(c)(6)(B) of the Social Security Act.”; and

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

23 (A) in subsection (a)—

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

4 (ii) in paragraph (2), by inserting
5 “(other than subsections (a) and (b) of
6 section 2799A–11)” after “part D”; and
7 (B) in subsection (b)—

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

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

14 (iii) in paragraph (2)(C)(ii), by insert-
15 ing “(other than subsections (a) and (b) of
16 section 2799A–11)” after “part D”.

17 (c) ERISA.—

18 (1) IN GENERAL.—Subtitle B of title I of the
19 Employee Retirement Income Security Act of 1974
20 (29 U.S.C. 1021 et seq.) is amended—

21 (A) in subpart B of part 7 (29 U.S.C.
22 1185 et seq.), by adding at the end the fol-
23 lowing:

1 **“SEC. 726. OVERSIGHT OF PHARMACY BENEFITS MANAGER**
2 **SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or
4 after the date that is 3 years after the date of enactment
5 of this section, a group health plan or health insurance
6 issuer offering group health insurance coverage, or an en-
7 tity or subsidiary providing pharmacy benefits manage-
8 ment services on behalf of such a plan or issuer, shall not
9 enter into a contract with a drug manufacturer, dis-
10 tributor, wholesaler, subcontractor, rebate aggregator, or
11 any associated third party that limits the disclosure of in-
12 formation to plan sponsors in such a manner that prevents
13 the plan or issuer, or an entity or subsidiary providing
14 pharmacy benefits management services on behalf of a
15 plan or issuer, from making the report described in sub-
16 section (b).

17 “(b) ANNUAL REPORT.—

18 “(1) IN GENERAL.—With respect to plan years
19 beginning on or after the date that is 3 years after
20 the date of enactment of this section, for each such
21 plan year, a group health plan or health insurance
22 issuer offering group health insurance coverage, or
23 an entity providing pharmacy benefits management
24 services on behalf of such a plan or an issuer, shall
25 submit to the plan sponsor (as defined in section
26 3(16)(B)) of such plan or coverage a report in a ma-

1 chine-readable format. Each such report shall in-
2 clude, with respect to such plan or coverage provided
3 for such plan year—

4 “(A) to the extent feasible, information col-
5 lected from drug manufacturers (or an entity
6 administering copay assistance on behalf of
7 such manufacturers) by such plan or issuer on
8 the total amount of copayment assistance dol-
9 lars paid, or copayment cards applied, that were
10 funded by the drug manufacturer with respect
11 to the participants, beneficiaries, and enrollees
12 in such plan or coverage;

13 “(B) a list of each drug covered by such
14 plan or coverage that was dispensed during the
15 plan year, including, with respect to each such
16 drug during such plan year—

17 “(i) the brand name, chemical entity,
18 and National Drug Code;

19 “(ii) the number of participants, bene-
20 ficiaries, and enrollees for whom the drug
21 was dispensed during the plan year, the
22 total number of prescription claims for the
23 drug (including original prescriptions and
24 refills), and the total number of dosage
25 units of the drug dispensed across the plan

1 year, disaggregated by dispensing channel
2 (such as retail, mail order, or specialty
3 pharmacy);

4 “(iii) the wholesale acquisition cost,
5 listed as cost per days supply and cost per
6 pill, or in the case of a drug in another
7 form, per dosage unit;

8 “(iv) the total out-of-pocket spending
9 by participants, beneficiaries, and enrollees
10 on such drug, including participant, bene-
11 ficiary, and enrollee spending through co-
12 payments, coinsurance, and deductibles;

13 “(v) for any drug for which gross
14 spending of the group health plan or
15 health insurance coverage exceeded
16 \$10,000 during the plan year—

17 “(I) a list of all other drugs in
18 the same therapeutic category or
19 class, including brand name drugs
20 and biological products and generic
21 drugs or biosimilar biological products
22 that are in the same therapeutic cat-
23 egory or class as such drug; and

24 “(II) the rationale for the for-
25 mulary placement of such drug in that

1 therapeutic category or class, if appli-
2 cable;

3 “(vi) the amount received, or expected
4 to be received, from drug manufacturers in
5 rebates, fees, alternative discounts, or
6 other remuneration for claims incurred for
7 such drug during the plan year;

8 “(vii) the total net spending, after de-
9 ducting rebates, price concessions, alter-
10 native discounts or other remuneration
11 from drug manufacturers, by the health
12 plan or health insurance coverage on such
13 drug; and

14 “(viii) the net price per course of
15 treatment or single fill, such as a 30-day
16 supply or 90-day supply, incurred by the
17 health plan or health insurance coverage
18 and its participants, beneficiaries, and en-
19 rollees, after manufacturer rebates, fees,
20 and other remuneration for such drug dis-
21 pensed during the plan year;

22 “(C) a list of each therapeutic category or
23 class of drugs that were dispensed under the
24 health plan or health insurance coverage during
25 the plan year, and, with respect to each such

1 therapeutic category or class of drugs, during
2 the plan year—

3 “(i) total gross spending by the plan
4 or coverage, before manufacturer rebates,
5 fees, or other manufacturer remuneration;

6 “(ii) the number of participants, bene-
7 ficiaries, and enrollees who were dispensed
8 a drug covered by such plan or coverage in
9 that category or class, broken down by
10 each such drug (identified by National
11 Drug Code);

12 “(iii) if applicable to that category or
13 class, a description of the formulary tiers
14 and utilization management (such as prior
15 authorization or step therapy) employed
16 for drugs in that category or class; and

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

22 “(D) total gross spending on prescription
23 drugs by the plan or coverage during the plan
24 year, before rebates and other manufacturer
25 fees or remuneration;

1 “(E) total amount received, or expected to
2 be received, by the health plan or health insur-
3 ance coverage in drug manufacturer rebates,
4 fees, alternative discounts, and all other remu-
5 neration received from the manufacturer or any
6 third party, other than the plan sponsor, re-
7 lated to utilization of drug or drug spending
8 under that health plan or health insurance cov-
9 erage during the plan year;

10 “(F) the total net spending on prescription
11 drugs by the health plan or health insurance
12 coverage during the plan year; and

13 “(G) amounts paid directly or indirectly in
14 rebates, fees, or any other type of remuneration
15 to brokers, consultants, advisors, or any other
16 individual or firm for the referral of the group
17 health plan’s or health insurance issuer’s busi-
18 ness to the pharmacy benefits manager.

19 “(2) PRIVACY REQUIREMENTS.—Health insur-
20 ance issuers offering group health insurance cov-
21 erage and entities providing pharmacy benefits man-
22 agement services on behalf of a group health plan
23 shall provide information under paragraph (1) in a
24 manner consistent with the privacy, security, and
25 breach notification regulations promulgated under

1 section 264(c) of the Health Insurance Portability
2 and Accountability Act of 1996, and shall restrict
3 the use and disclosure of such information according
4 to such privacy regulations.

5 “(3) DISCLOSURE AND REDISCLOSURE.—

6 “(A) LIMITATION TO BUSINESS ASSOCI-
7 ATES.—A group health plan receiving a report
8 under paragraph (1) may disclose such informa-
9 tion only to business associates of such plan as
10 defined in section 160.103 of title 45, Code of
11 Federal Regulations (or successor regulations).

12 “(B) CLARIFICATION REGARDING PUBLIC
13 DISCLOSURE OF INFORMATION.—Nothing in
14 this section prevents a health insurance issuer
15 offering group health insurance coverage or an
16 entity providing pharmacy benefits management
17 services on behalf of a group health plan from
18 placing reasonable restrictions on the public dis-
19 closure of the information contained in a report
20 described in paragraph (1), except that such
21 issuer or entity may not restrict disclosure of
22 such report to the Department of Health and
23 Human Services, the Department of Labor, the
24 Department of the Treasury, the Comptroller

1 General of the United States, or applicable
2 State agencies.

3 “(C) LIMITED FORM OF REPORT.—The
4 Secretary shall define through rulemaking a
5 limited form of the report under paragraph (1)
6 required of plan sponsors who are drug manu-
7 facturers, drug wholesalers, or other direct par-
8 ticipants in the drug supply chain, in order to
9 prevent anti-competitive behavior.

10 “(4) REPORT TO GAO.—A group health plan or
11 health insurance issuer offering group health insur-
12 ance coverage, or an entity providing pharmacy ben-
13 efits management services on behalf of a group
14 health plan shall submit to the Comptroller General
15 of the United States each of the first 4 reports sub-
16 mitted to a plan sponsor under paragraph (1) with
17 respect to such coverage or plan, and other such re-
18 ports as requested, in accordance with the privacy
19 requirements under paragraph (2), the disclosure
20 and redisclosure standards under paragraph (3), the
21 standards specified pursuant to paragraph (5), and
22 such other information that the Comptroller General
23 determines necessary to carry out the study under
24 section 2(d) of the Better Deals and Lower Prices
25 Act.

1 “(5) STANDARD FORMAT.—Not later than 18
2 months after the date of enactment of this section,
3 the Secretary shall specify through rulemaking
4 standards for health insurance issuers and entities
5 required to submit reports under paragraph (4) to
6 submit such reports in a standard format.

7 “(c) ENFORCEMENT.—

8 “(1) IN GENERAL.—Notwithstanding section
9 502, the Secretary, in consultation with the Sec-
10 retary of Health and Human Services and the Sec-
11 retary of the Treasury, shall enforce this section.

12 “(2) FAILURE TO PROVIDE TIMELY INFORMA-
13 TION.—A health insurance issuer or an entity pro-
14 viding pharmacy benefits management services that
15 violates subsection (a) or fails to provide information
16 required under subsection (b) shall be subject to a
17 civil monetary penalty in the amount of \$10,000 for
18 each day during which such violation continues or
19 such information is not disclosed or reported.

20 “(3) FALSE INFORMATION.—A health insurance
21 issuer or entity providing pharmacy benefits man-
22 agement services that knowingly provides false infor-
23 mation under this section shall be subject to a civil
24 money penalty in an amount not to exceed \$100,000
25 for each item of false information. Such civil money

1 penalty shall be in addition to other penalties as
2 may be prescribed by law.

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

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

17 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
18 tion shall be construed to permit a health insurance issuer,
19 group health plan, or other entity to restrict disclosure to,
20 or otherwise limit the access of, the Secretary of Labor
21 to a report described in subsection (b)(1) or information
22 related to compliance with subsection (a) or (b) by such
23 issuer, plan, or other entity subject to such subsections.

1 “(e) DEFINITION.—In this section, the term ‘whole-
2 sale acquisition cost’ has the meaning given such term in
3 section 1847A(c)(6)(B) of the Social Security Act.”; and

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

5 (i) in subsection (a)—

6 (I) in paragraph (6), by striking
7 “or (9)” and inserting “(9), or (13)”;

8 (II) in paragraph (10), by strik-
9 ing at the end “or”;

10 (III) in paragraph (11), at the
11 end by striking the period and insert-
12 ing “; or”; and

13 (IV) by adding at the end the fol-
14 lowing new paragraph:

15 “(12) by the Secretary, in consultation with the
16 Secretary of Health and Human Services, and the
17 Secretary of the Treasury, to enforce section 726.”;

18 (ii) in subsection (b)(3), by inserting
19 “and subsections (a)(12) and (c)(13)” be-
20 fore “, the Secretary is not”; and

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

23 “(13) SECRETARIAL ENFORCEMENT AUTHORITY
24 RELATING TO OVERSIGHT OF PHARMACY BENEFITS
25 MANAGER SERVICES.—

1 “(A) FAILURE TO PROVIDE TIMELY INFOR-
2 MATION.—The Secretary, in consultation with
3 the Secretary of Health and Human Services
4 and the Secretary of the Treasury, may impose
5 a penalty against any health insurance issuer or
6 entity providing pharmacy benefits management
7 services that violates section 726(a) or fails to
8 provide information required under section
9 726(b) in the amount of \$10,000 for each day
10 during which such violation continues or such
11 information is not disclosed or reported.

12 “(B) FALSE INFORMATION.—The Sec-
13 retary, in consultation with the Secretary of
14 Health and Human Services and the Secretary
15 of the Treasury, may impose a penalty against
16 a health insurance issuer or entity providing
17 pharmacy benefits management services that
18 knowingly provides false information under sec-
19 tion 726 in an amount not to exceed \$100,000
20 for each item of false information. Such penalty
21 shall be in addition to other penalties as may
22 be prescribed by law.

23 “(C) WAIVERS.—The Secretary may waive
24 penalties under subparagraph (A), or extend
25 the period of time for compliance with a re-

1 requirement of section 726, for an entity in viola-
2 tion of such section that has made a good-faith
3 effort to comply with such section.”.

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

 “Sec. 726. Oversight of pharmacy benefits manager services.”.

9 (d) GAO STUDY.—

10 (1) IN GENERAL.—Not later than 3 years after
11 the date of enactment of this Act, the Comptroller
12 General of the United States shall submit to Con-
13 gress a report on—

14 (A) pharmacy networks of group health
15 plans, health insurance issuers, and entities
16 providing pharmacy benefits management serv-
17 ices under such group health plan or group or
18 individual health insurance coverage, including
19 networks that have pharmacies that are under
20 common ownership (in whole or part) with
21 group health plans, health insurance issuers, or
22 entities providing pharmacy benefits manage-
23 ment services or pharmacy benefits administra-
24 tive services under group health plan or group
25 or individual health insurance coverage;

1 (B) as it relates to pharmacy networks
2 that include pharmacies under common owner-
3 ship described in subparagraph (A)—

4 (i) whether such networks are de-
5 signed to encourage enrollees of a plan or
6 coverage to use such pharmacies over other
7 network pharmacies for specific services or
8 drugs, and if so, the reasons the networks
9 give for encouraging use of such phar-
10 macies; and

11 (ii) whether such pharmacies are used
12 by enrollees disproportionately more in the
13 aggregate or for specific services or drugs
14 compared to other network pharmacies;

15 (C) whether group health plans and health
16 insurance issuers offering group or individual
17 health insurance coverage have options to elect
18 different network pricing arrangements in the
19 marketplace with entities that provide phar-
20 macy benefits management services, the preva-
21 lence of electing such different network pricing
22 arrangements;

23 (D) pharmacy network design parameters
24 that encourage enrollees in the plan or coverage
25 to fill prescriptions at mail order, specialty, or

1 retail pharmacies that are wholly or partially-
2 owned by that issuer or entity; and

3 (E) the degree to which mail order, spe-
4 cialty, or retail pharmacies that dispense pre-
5 scription drugs to an enrollee in a group health
6 plan or health insurance coverage that are
7 under common ownership (in whole or part)
8 with group health plans, health insurance
9 issuers, or entities providing pharmacy benefits
10 management services or pharmacy benefits ad-
11 ministrative services under group health plan or
12 group or individual health insurance coverage
13 receive reimbursement that is greater than the
14 median price charged to the group health plan
15 or health insurance issuer when the same drug
16 is dispensed to enrollees in the plan or coverage
17 by other pharmacies included in the pharmacy
18 network of that plan, issuer, or entity that are
19 not wholly or partially owned by the health in-
20 surance issuer or entity providing pharmacy
21 benefits management services.

22 (2) REQUIREMENT.—The Comptroller General
23 of the United States shall ensure that the report
24 under paragraph (1) does not contain information
25 that would allow a reader to identify a specific plan

1 or entity providing pharmacy benefits management
2 services or otherwise contain commercial or financial
3 information that is privileged or confidential.

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

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