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Summary of the Lower Costs, More Transparency Act

House leadership from the Energy and Commerce (E&C), Ways and Means (W&M) and Education and Workforce Committees introduced the Lower Costs, More Transparency Act – bipartisan legislation that largely includes previously marked up and advanced bills from the three Committees (press release; text; section-by-section). The legislation features the following provisions:

- Increasing transparency of hospital prices, clinical diagnostic laboratory test prices, imaging prices, ambulatory surgical center prices, health coverage prices, and pharmacy benefit manager (PBM) practices;
- Parity in Medicare payments for hospital outpatient department services furnished off-campus;
- Prohibiting spread pricing in Medicaid;
- The reauthorization for Community Health Centers, the Teaching Health Center GME program, National Health Service Corps; and the Special Diabetes Program;
- Delaying Disproportionate Share Hospital (DSH) reductions under Medicaid; and
- Increasing plan fiduciary access to health data and requiring hidden fee disclosures.

The legislation appropriates $37 million for implementation of various health care transparency requirements. Additionally, the legislation eliminates $7 billion in funds in the Medicaid Improvement Fund to offset program spending.

Related Congressional Activity: On the Senate side, the Health, Education, Labor, and Pensions (HELP) Committee has introduced the Primary Care and Health Workforce Expansion Act, which reauthorizes the same workforce programs as above and funds an additional 10,000 Medicare Graduate Medical Education slots. These provisions are partially offset broad site neutral provisions that would have prohibited hospitals from charging health plans and issuers a facility fee for services provided by off-site physicians or for providing on-site primary care, telehealth, and low-complexity services that can be safely provided in an ambulatory setting.

Regarding PBMs, the HELP Committee and the Senate Finance Committee (SFC) have each advanced their own package (the PBM Reform Act and the Modernizing and Ensuring PBM Accountability Act) that include PBM transparency, as well as provisions to prohibit spread pricing, require rebate pass-through, and delink PBM reimbursement from drug prices and utilization.

Next Steps. This package could get floor consideration in the House later this month.

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Title I – Improving Health Care Transparency

- **Sec. 101. Hospital Price Transparency Requirements** – Beginning January 1, 2026, hospitals will be required to compile and make public the following information in a format specified by the HHS Secretary. The requirements apply to hospitals and ambulatory surgical center (ASC) that receive Medicare payments for furnishing items and services; and hospitals that receive payment from health insurance issuers offering group or individual health insurance coverage.
    - All of the hospital's standard charges for each item and service furnished by the hospital, including:
        - A plain language description of each item or service and code;
        - Gross charge in the inpatient setting and outpatient department setting;
        - Discounted cash price or median cash price charged by the hospital to self-pay individuals;
        - Payer-specific negotiated charges;
        - De-identified maximum and minimum negotiated charges; and
        - Any other additional information required by the HHS Secretary
    - Information in consumer-friendly format:
        - On the hospital's prices for at least 300 shoppable services (including as many of the CMS-shoppable services furnished by the hospital and additional hospital-selected shoppable services)
        - A list of CMS-specified shoppable services that is not furnished by the hospital

  No later than January 1, 2026, the HHS Secretary will be required to establish a standard, uniform method and format for specified facilities to use in compiling and making public standard charges and prices, which may be similar to any template made available by CMS.

  Through notice and comment rulemaking, the HHS Secretary will establish a process to monitor compliance with reporting requirements. Enforcement mechanisms include a process requiring noncompliant hospitals to submit and implement a corrective action plan. The HHS Secretary may levy civil monetary penalties for ongoing noncompliance:

    - For a hospital 30 or fewer beds, $300 per day (or if noncompliant for a 1-year period or longer, $400 per day)
    - For a hospital with more than 30 beds but fewer than 101 beds, $10 per bed per day (or if noncompliant for a 1-year period or longer, $15 per bed per day);
    - For a hospital with more than 100 beds but fewer than 301 beds, $12.50 per bed per day (or if noncompliant for a 1-year period or longer, $20 per bed per day)

- For a hospital with more than 300 beds but fewer than 501 beds, $17.50 per bed per day (or if noncompliant for a 1-year period or longer, $25 per bed per day); and
- For a hospital with more than 300 beds, $25 per bed per day (or if noncompliant for a 1-year period or longer, $35 per bed per day).
- Through notice and comment rulemaking, the HHS Secretary may increase the amount of penalties for violations occurring in 2027 or a subsequent year.
- The HHS Secretary may also levy additional civil monetary penalties, ranging from $500,000 to $10 million (depending on number of beds), on facilities that are persistently noncompliant (i.e., two or more time during a 1-year period).
- The HHS Secretary is authorized to waive any penalty, or reduce penalty by no more than 75 percent, if the penalty would result in an immediate threat to access to care for individuals in the service area of the hospital, subject to some limitations.

Beginning January 1, 2026, the HHS Secretary will make publicly available on a CMS website real-time information with respect to compliance with the requirements and enforcement activities undertaken by the Secretary. This information includes:

- Number of review of compliance undertaken by the Secretary;
- Number of notifications sent by the Secretary to noncompliant facilities;
- The identify of each hospital that was sent such a notification and a description of the nature of such hospital's noncompliance;
- The amount of any civil monetary penalty imposed on such hospital;
- Whether such hospital subsequently came into compliance;
- Any waivers or reductions of penalties, including the name of any specified hospital that received such a waiver or reduction, the dollar amount of such penalty so waived or reduce; and the rationale for granting the waiver or reduction; and
- Any information as determined by the Secretary.

- **Sec 102. Increasing Price Transparency of Clinical Diagnostic Laboratory Tests Under the Medicare Program** – Starting January 1, 2026, clinical laboratories that receive Medicare payments for specified clinical diagnostic laboratory tests must make certain information publicly available on a designated website. This information must be updated at least annually and include the following:
  - The discounted cash price for the test or, if not available, the gross charge for the test;
  - The de-identified minimum payer-specific negotiated charge for the test; and
  - The de-identified maximum payer-specific negotiated charge between the laboratory and any third-party payer for the test.

The section requires the Secretary to establish a standard, uniform method, and format for laboratories to use in presenting this information by January 1, 2026. Additionally, prices or rates for clinical diagnostic laboratory tests must also include the cost of ancillary items or services (e.g., specimen collection services) provided by the laboratory as part of the test. The section includes definitions for key terms such as "applicable laboratory," "discounted cash price," "gross charge," "payer-specific negotiated charge," "specified clinical diagnostic laboratory test," and "third-party payer." The Secretary also is authorized to levy civil monetary penalties.

- **Sec 103. Imaging Transparency** – Starting January 1, 2028, healthcare providers and suppliers receiving Medicare payments for specific imaging services must:
    - Make pricing information publicly available on a website for each imaging service they offer.
    - Ensure that this information is updated at least annually.

  The required information includes the discounted cash price for the service (or the gross charge if no discounted price exists) and, if required by the Secretary, the de-identified minimum and maximum payer-specific negotiated charges. The section requires the Secretary to establish a standardized format for presenting this information by January 1, 2028, to ensure accessibility and usability.

- **Sec 104. Ambulatory Surgical Center Price Transparency Requirements** – Starting on January 1, 2026, ambulatory surgical centers (ASCs) owned by hospitals that receive payment under the act for providing items and services must comply with the following price transparency requirements:
    - ASCs must compile and make public, in a format specified by the Secretary, a list of standard charges for each item and service they offer. This information must be made available without any subscription or charge.
    - ASCs must provide information in a consumer-friendly format about their prices for CMS-specified shoppable services, as well as additional ambulatory surgical center-selected shoppable services. This should include descriptions, gross charges, discounted cash prices, payer-specific negotiated charges, and other relevant details.
    - For services not offered by the ambulatory surgical center, they must indicate that such services are not available.

  The section requires the Secretary to establish uniform methods and formats for making this pricing information publicly available, ensuring machine-readable formats and other accessibility standards by January 1, 2026. ASCs would be deemed in compliance with the shoppable services requirement if they maintain a price estimator tool that allows individuals to obtain price estimates for specified services. The tool must meet the following requirements:

- It allows individuals to immediately obtain price estimates for CMS-specified shoppable services and additional shoppable services selected by the ASC. These estimates should be available for at least 300 shoppable services (or all such services if the center offers fewer than 300);
- The tool allows individuals to obtain estimates by billing code and service description;
- It is prominently displayed on the public internet website of the ASC;
- The tool does not require individuals seeking an estimate to create an account or provide personal information, except for information specified by the Secretary, which may include identifiers assigned by health plans or programs; and
- The tool contains a statement confirming the accuracy and completeness of the information presented.

The Secretary will monitor compliance through a review process conducted at least once every three years. Additionally, the Secretary would be allowed to waive or reduce penalties for ASCs facing significant hardship, such as those in rural or underserved areas.

- **Sec. 105. Promoting Health Coverage Price Transparency** – For plan years beginning on or after January 1, 2026, group health plans and health insurance issuers offering group or individual health insurance coverage must allow individuals to learn their cost-sharing responsibility with respect to the furnishing of an item or service by a provider in a timely manner upon request of the individual. At a minimum, such information should include the following through a self-service tool:
  - If the provider is in-network; the in-network rate;
  - If the provide is out-of-network; the maximum allowed amount for such item or service;
  - The estimated amount of cost sharing that the participant of beneficiary will incur for such item or service calculated using the maximum amount allowed;
  - The amount the participant has already accumulated with respect to any deductible or out-of-pocket maximum under the plan;
  - In the case that such plan imposes any frequency or volume limitations, the amount that such beneficiary has accrued towards such limitations;
  - Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to coverage of such item or service under such plan; and
  - Any shared savings (such as any credit, payment, or other benefit provided by such plan) available to the individual.

  Such information should be made available through a self-service tool, or at the option of the such individual, through a paper disclosure or phone or other electronic disclosure. A self-service tool must meet the following requirements:

  - Is based on an internet website;

- Provide real-time responses to the requests;
- Is updated is a manner such that information provided through the tool is timely and accurate at the time such request is made;
- Allows such a request to be made by all providers;
- Provides that such a request may be made through the use of billing code or a descriptive term for such item or service; and
- Meets any other requirements determined by the Secretary.

For plan years beginning on or after January 1, 2026, group health plans are required to publish, on a monthly basis, the rate and payment information for the following:

- The in-network rate with each provider for each item and service;
- The in-network rate and the average amount paid by such plan (net of rebates, discounts, and price concessions) for each drug covered and dispensed during the 90-day period beginning 180 days before such date of publication; and
- With respect to each item and service, the amount billing, and the amount allowed by the plan, during the 90-day period specified above.

For plan years beginning or after January 1, 2026, each group health plan is required to make public a data file that may be easily downloaded (i.e., spreadsheet) with the following information. Plans will also be required to submit an attestation.

- The mean, median, and interquartile range of the in-network rate, and amount allowed for an item or service when not furnished by a participating provider;
- Trends in payment rates for such items and services over such plan year;
- The name of such plan, a description of the type of network of participating providers, and a description of whether such plan is self-insured or fully-insured;
- For each item or service which is paid as part of a bundled rate – a description of the pricing methodologies and a list of items and services included in the bundle
- The percentage of items and services that are paid for on a fee-for-service basis and the percentage of items and services that are paid as part of a bundled rate, capitated payment rate, or other alternative payment model.

- **Sec. 106 Oversight of PBM Services** – For plan years beginning on or after the date that is 2 years after the date of enactment, and not less frequently than every 6 months thereafter, PBMs are required to submit the following information to plan sponsors and make such a report available in a machine-readable format:
  - A list of each drug covered by the plan that was dispensed during the reporting period, including:

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- The brand name, chemical entity, and NDC;
- The type of dispensing channel used to furnish such drug, including retail, mail order, or specialty pharmacy;
- With respect to each drug dispensed under each type of dispensing channel:
    - Whether such drugs is a brand name drug or a generic drug and
        - In the case of a brand name drug, the WAC listed as cost per days supply and cost per dosage unit, on the date such drug was dispensed; and
        - In the case of a generic drug, the average wholesale price, listed a cost per days supply and per dosage unit, on the date such drug was dispensed;
    - The total number of:
        - Prescription claims
        - Participants and beneficiaries for whom a claim for such drug was filed;
        - The dosage units per fill of such drug; and
        - Days supply of such drug per fill.
    - The net price per course of treatment or single fill, such as 30-day supply or 90-day supply to the plan or coverage after manufacturer rebates, fee, and other remuneration;
    - The total OOP spending by participant and beneficiary spending through copayments, coinsurance, and deductibles;
    - The total net spending by the plan or coverage;
    - The total amount received, or expected to be received, by the plan or coverage from any entity in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from an entity or any third party other than the drug sponsor;
    - The total amount received, or expected to be received, by the plan or issuer, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration –
        - That has been paid, or is to be paid, by drug manufacturers for claims incurred during the reporting period; and
        - That is related to utilization rebates for such drug;
- To the extent feasible, information on the total amount of renumeration, including copayment assistance dollars paid, copayment cards applied, or other discounts provided by each drug manufacturer (or entity administering copay assistance on behalf of a manufacturer) to the participants and beneficiaries enrolled in such plan or coverage.

- For each category or class of drugs for which a claim was filed, a breakdown of the total gross spending on drugs in such category or class, before rebates, price concessions, alternative discounts, or other remuneration from drug manufacturers, and the net spending after such rebates, price concessions, alternative discounts, or other remuneration, including –
  - The number of participants and beneficiaries who fille a prescription for a drug in such category or class, including NDC for each such drug;
  - If applicable, a description of the formulary tiers and utilization mechanisms (such as prior auth or step therapy) employed for drugs in that class or category; and
  - The total OOP spending by participants and beneficiaries, including spending through copayment, coinsurance, and deductible;
- In the case of a drug for which gross spending by such plan exceeded $10,000 during the reporting period:
  - A list of all other drugs in the same therapeutic category or class; and
  - Rationale for preferred formulary placement of such drug in that therapeutic category or class, if applicable.

- Amounts paid directly or indirectly in rebates, fees, or other remuneration to brokers, consultants, advisors, who referred the health plan to the PBM.
- An explanation of any benefit design parameters that encourage or require participants and beneficiaries to fill prescriptions at mail order, specialty, or retail pharmacies that are affiliated with, or under common ownership with the entity providing PBM services, including mandatory mail and specialty home delivery program, retail and mail auto-refill programs, and cost sharing assistance incentives funded by such entity; and
- In the case of a plan or coverage that has an affiliated pharmacy –
  - The percentage of total prescription dispensed by such pharmacies to individual enrolled in such plan or coverage;
  - A list of all drugs dispensed by such pharmacies to individuals enrolled in such plan or coverage, and with respect to each drug dispensed:
    - The amount charged, per dosage unit, per 30-day supply, or per 90-day supply to the plan or issuer and to participants and beneficiaries enrolled in such plan or coverage;
    - The median amount charged to such plan or issuer, and the interquartile range of the costs, per dosage unit, per 30-day supply, or per 90-day supply, including amounts paid by the participants and beneficiaries when the same drug is dispensed by other pharmacies that are not affiliated with the PBM;
    - The lowest cost per dosage unit, per 30-day supply, or per 90-day supply, for each such drug, including amounts charged to the plan and beneficiaries that is

available from any pharmacy included in the network of such plan or coverage; and

- The net acquisition cost per dosage unit, per 30-day supply, or per 90-day supply, if such drug is subject to a maximum price discount.

- **Sec. 107. Reports on Health Care Transparency Tools and Data Requirements** – GAO is required to submit to relevant congressional committees reports on health care transparency tools and federal health care reporting requirements in effect, how reporting requirements are enforced, and impact of transparency tools and reporting requirements (consumer utilization and value, improved benefits, lower costs). The initial report is due December 31, 2024; and the final report is due December 31, 2028. GAO is also required to deliver a report on expanding price transparency requirements to additional care settings, due December 31, 2025.

- **Sec. 108. Report on Integration in Medicare** – For plan years beginning on or after January 1, 2025, and every third plan year thereafter, each MA organization offering an MA plan must submit the taxpayer identification number for each specified health care provider; the total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from the specified provider during the plan year; and the total amount of incentive-based payments made to, and the total amount of shared losses recoupments collected from other providers. A specified health care provider is a provider of services or supplier to which such MA organization has an ownership stake or controls interest. This requirement applies to MA organizations with at least 25,000 individuals enrolled under MA plans for such plan year.

  For plan years beginning on or after January 1, 2025, and every third plan year thereafter, each PDP offering a prescription drug plan must submit the taxpayer identification number and National Provider Identifier for each pharmacy that was a specified pharmacy with respect to such sponsor during such year. A specified pharmacy is defined as, with respect to a PDP, a pharmacy to which such sponsor has an ownership or control interest, or a PBM offering services under such plan has ownership or control interest.

  The section also requires MedPAC reports on the state of vertical integration in the health care sector with respect to entities participating in Medicare, including providers, pharmacies, prescription drug plan sponsors, MA organizations, and pharmacy benefit managers. The report is due June 15, 2029 and every 3 years thereafter.

- **Sec. 109. Advisory Committee** – This section would establish a 9-member Advisory Committee, no later than January 1, 2025, to advise the Secretaries of Labor, HHS, and Treasury on how to

improve the accessibility, usefulness and usability of information collected through sections 105 and 106 of this Act and Section 204 of the Consolidated Appropriations Act of 2021. Section 204 mandates employer-based health plans and insurance companies and provides information pertaining to healthcare and prescription drug spending to CMS. The Secretaries of Labor, HHS and Treasury will appoint members to serve on the Advisory Committee, including when a seat becomes vacant. The committee will sunset on January 1, 2028.

- **Sec. 110. Report on Impact of Medicare Regulations on Provider and Payer Consolidation** – This section requires that the Secretary of HHS submit an annual report to Congress detailing the impact of Medicare regulations and CMS Innovation demonstrations on provider and payer consolidation. This reporting requirement would begin in 2026 and apply every year after. Beginning in 2025, CMS would also be required to request public comment on the impact of proposed Medicare regulations on health care consolidation.

- **Sec. 111. Implementation Funding** – This section appropriations $25 million for FY 2024 to remain available through FY 2029 to the HHS Secretary and Treasury Secretary for implementation activities in Title I, such as issuing regulations and guidance, preparing reports, enforcing provisions, and collecting and analyzing data. Each Secretary is required to annually submit, no later than September 1 of each year, a report to relevant committees on funds expended.

Title II – Reducing Health Care Costs for Patients

- **Sec. 201. Increasing Transparency in Generic Drug Applications** – This section streamlines the approval process for generic drugs by requiring the Food and Drug Administration (FDA) to disclose differences between the generic and brand drug during the approval process. Specifically, if the Secretary determines that the generic drug applicant is not qualitatively or quantitatively the same as the listed drug, the Secretary can disclose the following information:
    - The ingredient or ingredients that cause such drug not to be qualitatively or quantitatively the same as the listed drug; and
    - For any ingredient for which there is an identified quantitative deviation, the amount of such deviation.

- **Sec. 202. Improving Transparency and Preventing the Use of Abusive Spread Pricing and Related Practices in Medicaid** – Prohibits spread pricing in Medicaid by requiring PBMs to make payments based on a pass-through pricing model under which:

- Payment made by the PBM is limited to the ingredient cost and a professional dispensing fee that is not less than the professional dispensing fee that the State plan or Waiver would pay if the plan was making the payment directly; and
- Is passed through in its entirety to the pharmacy or provider who dispenses the drug.

Additionally, payment to the PBM for administrative services is limited to an administrative fee that reflect the fair market value of providing such services.

- **Sec. 203. Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus-**This provision is the same as the provision included in H.R. 4822, the Health Care Price Transparency Act marked up by the Ways and Means Committee. It would make covered OPD services included in the ambulatory payment classification (APC) groups for drug administration services furnished by an off-campus OPD site neutral starting in 2025 with a 4-year phase-in. There is a one-year delay in implementation for cancer hospitals or hospitals located in a rural or health professional shortage area. The bill would not permit the change to be implemented in a budget neutral way, meaning it would generate savings. This provision was included in the PATIENT Act but adds the one-year delay for certain hospitals.

- **Sec. 204. Requiring a Separate Identification Number and an Attestation for Each Off Campus Outpatient Department of a Provider-** This provision requires that for any off-campus outpatient department of a provider to receive reimbursement they must obtain, and subsequently submit claims, under a standard unique health identifier for health care providers that is separate from the provider's identifier. The provision further requires the provider to submit to the Secretary an attestation that the outpatient department has been compliant with their provider-based status for the previous 2 years. The Secretary is required to establish a process for providers to submit attestations through the public notice and rule making process within a year of the bill's enactment. The Secretary will further establish how the attestations will be reviewed and determine, through site visits, remote audits, or other means (as determined appropriate by the Secretary), whether such department is compliant with the requirements. Finally, the HHS OIG is required to submit to Congress an analysis of the process to conduct reviews and determinations that was established by the Secretary.

Title III – Supporting Patients, Health Care Workers, Community Health Centers, and Hospitals

- **Sec. 301. Extension for Community Health Centers, the National Health Service Corps, and Teaching Health Centers that Operate GME Programs** – This section would reauthorize the Community Health Center Fund that makes up 70 percent of the federal funds for health centers

through calendar year 2025 at $4.4 billion per year. It also reauthorizes the National Health Service Corps through calendar year 2025 at $350 million per year. The National Health Service Corps supports more than 20,000 primary care medical, dental, and behavioral health providers through scholarships and loan repayment programs. It also provides a corps of health professionals that serve at more than 9,000 community health care sites seeing more than 21 million patients. This section further reauthorizes the Teaching Health Center Graduate Medical Education Program for FY24-29, beginning at $175 million in FY24 and increasing to $300 million for each of FY28,29, and 30. Finally, this section allows HRSA to utilize carryover funds for the THCGME program for FY24 and FY25.

- **Sec. 302. Special Diabetes Programs** – This section would extend both the Special Diabetes Program and Special Diabetes for Indians Program through calendar year 2025 at $170 million respectively.

- **Sec. 303. Delaying Certain Disproportionate Share Hospital Payment Reductions Under Medicaid** – This section would eliminate the Medicaid Disproportionate Share Hospital (DSH) cuts for FY24-25. The cuts equate to $8 billion per year in Medicaid funding that is otherwise meant to support high-need hospitals that provide care for high rates of Medicaid and uninsured patients.

- **Sec. 304. Medicaid Improvement Fund** – This section would remove $7 billion in funding from the Medicaid Improvement Fund.

Title IV – Increasing Access to Quality Health Data and Lowering Hidden Fees

- **Sec. 401. Increasing Plan Fiduciaries' Access to Health Data** – The section stipulates that no contract or arrangement for services between a group health plan and any other entity, such as a health care providers, third-party administrators, or PBMs, is reasonable within the meaning of this paragraph unless such contract or agreement includes the following:

    - Allows the responsible plan fiduciary to audit all de-identified claims and encounter information or data to: 1) ensure that such entity complies with the terms of the plan and any applicable law; 2) determine the reasonableness of compensation by the plan; and 3) does not
        - Unreasonably limit the number of audits permitted during a given period of time;
        - Limit the number of deidentified claims and encounter information;

- Limit the disclosure of pricing terms for value based payment arrangements, including payment calculations and formular, quality measures, payment amounts, measurement periods, and other payment methodologies;
- Limit the disclosure of overpayments and overpayment recovery terms;
- Limit the right of the responsible plan fiduciary to select an auditor;
- Otherwise limit or unduly delay by greater than 60 days the responsible plan fiduciary from auditing such information or data; or
- Charge a fee beyond the reasonable direct costs to administer the operation of conducting such audits.

No later than 1 year after enactment, the Secretary of Labor is request to submit a report on the status of de-identified claims and encounter information or data, including information on:

- Whether changes to regulation or guidance would permit such information or data to deemed a group health plan asset;
- Whether restrictions on the ability of a plan fiduciary to access such information or data violates a requirement of current law;
- The existing regulatory authority of the Secretary to clarify whether such information or data is the property of a group health plan, rather than a service provider;
- Legislative actions that may be taken to establish such information or data related to a plan belong to a group health plan and is handled in the best interests of plan participants and beneficiaries.

- **Sec. 402. Hidden Fees Disclosure Requirement**

  - **Clarification of the Application of Fee Disclosure to Covered Service Providers:** The bill would add contracts or arrangements for services between a covered plan and a health insurance issuer providing coverage in connection with the plan in which the insurance issuer contracts for PBM services to the definition of "indirect furnishing of goods, services, or facilities between the plan and service provider acting as the party in interest" for the purposes of disclosure requirements.

  - **Strengthening Disclosure Requirements with Respect to PBMs and TPA**: The section would also add disclosure requirements for contracts or arrangements with a covered plan in connection with the provision of PBM services. Reporting requirements to fiduciaries would include:

    - With respect to a contract or arrangement with the covered plan in connection with the provision of PBM services:

- All compensation, including fees, rebates, alternative discounts, copayment offsets, and other remuneration expected to be received by the covered service provide, an affiliate, or subcontractor from a pharmaceutical manufacturer, distributor, rebate aggregator, accumulator and maximizer, group purchasing organization, or any other third party;
- The amount and form of any rebates, discounts, or price concessions, including the amount expected to be passed through to the plan sponsor or the beneficiaries under the plan;
- All compensation expected to be received by the covered service provider as a result of paying a lower amount for the drug than the amount charged as a copayment, coinsurance, or deductible;
- All compensation expected to be received by the covered service provider as a result of paying pharmacies less than what is charged to the health plan, plan sponsor, or beneficiaries; and
- All compensation expected to be received by the covered service provider from drug manufacturers or any other third party for administering or collecting rebates related to the covered plan, providing business services such as access to drug utilization data, keeping a percentage of the list price, or any other reason related to the role of a covered service provider as a conduit between drug manufacturers and any other third party and the covered plan.

- Annual reporting requirements for covered service providers regarding contracts or arrangements with the covered plan in connection with providing PBM services would now include the following direct and indirect compensation information for the previous year within 60 days of the beginning of the current plan year:

    - All direct compensation and indirect compensation received by the covered service provider;
    - For each drug covered under the covered plan, the amount by which the price for the drug paid by the plan exceeds the amount paid to pharmacies by the covered service provider;
    - The total gross spending by the covered plan on drugs, excluding rebates and prices concession;
    - The net spending by the covered plan on drugs;
    - The total gross spending at all pharmacies wholly or partially owned by the covered service provider;

- The aggregate amount of clawback from pharmacies including mail-order, specialty, and retail, including categorical explanations for clawbacks or individual explanations;
- Total aggregate amounts of fees collected by the covered service provider in connection with the provision of PBM services to the plan; and
- Any other information that may be necessary for a plan fiduciary to consider the merits of the contract or arrangement and any conflicts of interest.

- Additionally, the bill would establish similar reporting requirements for third-party administrators (TPAs) for group health plans. For disclosure requirements to a responsible plan fiduciary, TPAs would report the following with respect to a contract or arrangement with a plan in connection with the provision of TPA services:
  - The amount and form of any rebates, discounts, savings fees, refunds, or amounts received from providers and facilities, including amounts that will be retained by the covered service provider as a fee;
  - The amount and form of fees expected to be received from other service providers in relation to the covered plan, including amounts that will be retained by the covered service provider as a fee; and
  - The amount and form of expected recoveries by the covered service provider including amounts that will be retained as a fee as a result of overpayments, erroneous payments, uncashed checks or incomplete payments, billing errors, subrogation, fraud, or any other reason.

- The bill would also include annual reporting requirements for TPA contracts that include the following within 60 days of the beginning of the plan year, with respect to the previous year:
  - All direct and indirect compensation, including that which was described above;
  - The aggregate amount for which the covered service provider received indirect compensation and the estimated amount of cost-sharing incurred by beneficiaries as a result;
  - Total gross spending by the covered plan on all costs and fees under the administrative services agreement with the TPA;
  - Total net spending by the covered plan on all costs and fees arising under or paid under the administrative services agreement with the covered service provider;
  - Aggregate fees collected by the service provider; and
  - Any other information that may be necessary for a plan fiduciary to consider the merits of the arrangement and any conflicts of interest.

- **Sec. 403. Prescription Drug Price Information Requirement** – This section would prohibit health plans or issuers from restricting any pharmacy that dispenses a drug to an enrollee in the plan from informing an enrollee of the differential between the out-of-pocket cost under the plan and the amount an individual would pay without insurance coverage. Issuers and plans would also be required to ensure that an entity that provides PBM services under contract with the plan does not restrict a pharmacy from informing an enrollee of the difference between the out-of-pocket cost under their coverage and the amount an individual would pay without coverage.

- **Sec. 404. Implementation Funding** – This section would appropriate $12 million for FY 2024, to remain available through FY 2029, to the Secretary of Labor for implementation activities in Title IV, such as issuing regulations and guidance, preparing reports, enforcing provisions, and collecting and analyzing data. The Labor Secretary is required to annually submit, no later than September 1 of each year, a report to relevant committees on funds expended.