

**AMENDMENT TO**  
**RULES COMMITTEE PRINT 117-51**  
**OFFERED BY M . \_\_\_\_\_**

Amend section 263 to read as follows:

1 **SEC. 263. REQUIRING PRESCRIBERS OF CONTROLLED SUB-**  
2 **STANCES TO COMPLETE TRAINING.**

3 Section 303 of the Controlled Substances Act (21  
4 U.S.C. 823) is amended by adding at the end the fol-  
5 lowing:

6 “(1) REQUIRED TRAINING FOR PRESCRIBERS.—

7 “(1) TRAINING REQUIRED.—As a condition on  
8 registration under this section to dispense controlled  
9 substances in schedule II, III, IV, or V, the Attorney  
10 General shall require any qualified practitioner, be-  
11 ginning with the first applicable registration for the  
12 practitioner, to meet the following:

13 “(A) If the practitioner is a physician (as  
14 defined under section 1861(r) of the Social Se-  
15 curity Act), the practitioner meets one or more  
16 of the following conditions:

17 “(i) The physician holds a board cer-  
18 tification in addiction psychiatry or addic-

1                   tion medicine from the American Board of  
2                   Medical Specialties.

3                   “(ii) The physician holds a board cer-  
4                   tification from the American Board of Ad-  
5                   diction Medicine.

6                   “(iii) The physician holds a board cer-  
7                   tification in addiction medicine from the  
8                   American Osteopathic Association.

9                   “(iv) The physician has, with respect  
10                  to the treatment and management of pa-  
11                  tients with opioid or other substance use  
12                  disorders, or the safe pharmacological  
13                  management of dental pain and screening,  
14                  brief intervention, and referral for appro-  
15                  priate treatment of patients with or at risk  
16                  of developing opioid or other substance use  
17                  disorders, completed not less than 8 hours  
18                  of training (through classroom situations,  
19                  seminars at professional society meetings,  
20                  electronic communications, or otherwise)  
21                  that is provided by—

22                  “(I) the American Society of Ad-  
23                  diction Medicine, the American Acad-  
24                  emy of Addiction Psychiatry, the  
25                  American Medical Association, the

1 American Osteopathic Association, the  
2 American Dental Association, the  
3 American Association of Oral and  
4 Maxillofacial Surgeons, the American  
5 Psychiatric Association, or any other  
6 organization accredited by the Accred-  
7 itation Council for Continuing Medical  
8 Education (commonly known as the  
9 ‘ACCME’) or the Commission on  
10 Dental Accreditation;

11 “(II) any organization accredited  
12 by a State medical society accreditor  
13 that is recognized by the ACCME or  
14 the Commission on Dental Accredita-  
15 tion;

16 “(III) any organization accred-  
17 ited by the American Osteopathic As-  
18 sociation to provide continuing med-  
19 ical education; or

20 “(IV) any organization approved  
21 by the Assistant Secretary for Mental  
22 Health and Substance Abuse, the  
23 ACCME, or the Commission on Den-  
24 tal Accreditation.

1           “(v) The physician graduated in good  
2 standing from an accredited school of  
3 allopathic medicine, osteopathic medicine,  
4 dental surgery, or dental medicine in the  
5 United States during the 5-year period im-  
6 mediately preceding the date on which the  
7 physician first registers or renews under  
8 this section and has successfully completed  
9 a comprehensive allopathic or osteopathic  
10 medicine curriculum or accredited medical  
11 residency or dental surgery or dental medi-  
12 cine curriculum that included not less than  
13 8 hours of training on—

14           “(I) treating and managing pa-  
15 tients with opioid and other substance  
16 use disorders, including the appro-  
17 priate clinical use of all drugs ap-  
18 proved by the Food and Drug Admin-  
19 istration for the treatment of a sub-  
20 stance use disorder; or

21           “(II) the safe pharmacological  
22 management of dental pain and  
23 screening, brief intervention, and re-  
24 ferral for appropriate treatment of pa-  
25 tients with or at risk of developing

1                   opioid and other substance use dis-  
2                   orders.

3                   “(B) If the practitioner is not a physician  
4                   (as defined under section 1861(r) of the Social  
5                   Security Act), the practitioner meets one or  
6                   more of the following conditions:

7                   “(i) The practitioner has completed  
8                   not fewer than 8 hours of training with re-  
9                   spect to the treatment and management of  
10                  patients with opioid or other substance use  
11                  disorders (through classroom situations,  
12                  seminars at professional society meetings,  
13                  electronic communications, or otherwise)  
14                  provided by the American Society of Addic-  
15                  tion Medicine, the American Academy of  
16                  Addiction Psychiatry, the American Med-  
17                  ical Association, the American Osteopathic  
18                  Association, the American Nurses  
19                  Credentialing Center, the American Psy-  
20                  chiatric Association, the American Associa-  
21                  tion of Nurse Practitioners, the American  
22                  Academy of Physician Associates, or any  
23                  other organization approved or accredited  
24                  by the Assistant Secretary for Mental  
25                  Health and Substance Abuse or the Ac-

1                   creditation Council for Continuing Medical  
2                   Education.

3                   “(ii) The practitioner has graduated  
4                   in good standing from an accredited physi-  
5                   cian assistant school or accredited school  
6                   of advanced practice nursing in the United  
7                   States during the 5-year period imme-  
8                   diately preceding the date on which the  
9                   practitioner first registers or renews under  
10                  this section and has successfully completed  
11                  a comprehensive physician assistant or ad-  
12                  vanced practice nursing curriculum that  
13                  included not fewer than 8 hours of training  
14                  on treating and managing patients with  
15                  opioid and other substance use disorders,  
16                  including the appropriate clinical use of all  
17                  drugs approved by the Food and Drug Ad-  
18                  ministration for the treatment of a sub-  
19                  stance use disorder.

20                  “(2) ONE-TIME TRAINING.—

21                  “(A) IN GENERAL.—The Attorney General  
22                  shall not require any qualified practitioner to  
23                  complete the training described in clause (iv) or  
24                  (v) of paragraph (1)(A) or clause (i) or (ii) of  
25                  paragraph (1)(B) more than once.

1           “(B) NOTIFICATION.—Not later than 90  
2           days after the date of the enactment of the Re-  
3           storing Hope for Mental Health and Well-Being  
4           Act of 2022, the Attorney General shall provide  
5           to qualified practitioners a single written, elec-  
6           tronic notification of the training described in  
7           clauses (iv) and (v) of paragraph (1)(A) or  
8           clauses (i) and (ii) of paragraph (1)(B).

9           “(3) RULE OF CONSTRUCTION.—Nothing in  
10          this subsection shall be construed to preclude the  
11          use, by a qualified practitioner, of training received  
12          pursuant to this subsection to satisfy registration re-  
13          quirements of a State or for some other lawful pur-  
14          pose.

15          “(4) DEFINITIONS.—In this section:

16                 “(A) FIRST APPLICABLE REGISTRATION.—  
17                 The term ‘first applicable registration’ means  
18                 the first registration or renewal of registration  
19                 by a qualified practitioner under this section  
20                 that occurs on or after the date that is 180  
21                 days after the date of enactment of the Restor-  
22                 ing Hope for Mental Health and Well-Being  
23                 Act of 2022.

1                   “(B) QUALIFIED PRACTITIONER.—In this  
2                   subsection, the term ‘qualified practitioner’  
3                   means a practitioner who—

4                               “(i) is licensed under State law to pre-  
5                               scribe controlled substances; and

6                               “(ii) is not solely a veterinarian.”.

Page 150, after line 5, insert the following:

7   **SEC. 312. REAUTHORIZATION OF MINORITY FELLOWSHIP**  
8                   **PROGRAM.**

9                   Section 597(c) of the Public Health Service Act (42  
10 U.S.C. 2901(c)) is amended by striking “\$12,669,000 for  
11 each of fiscal years 2018 through 2022” and inserting  
12 “\$25,000,000 for each of fiscal years 2023 through  
13 2027”.

At the end of title IV, add the following new sub-  
title:

14                   **Subtitle D—Media and Mental**  
15                               **Health**

16   **SEC. 431. STUDY ON THE EFFECTS OF SMARTPHONE AND**  
17                   **SOCIAL MEDIA USE ON ADOLESCENTS.**

18                   (a) IN GENERAL.—Not later than 1 year after the  
19 date of enactment of this Act, the Secretary of Health and  
20 Human Services shall conduct or support research on—



1 (1) smartphone and social media use by adoles-  
2 cents; and

3 (2) the effects of such use on—

4 (A) emotional, behavioral, and physical  
5 health and development; and

6 (B) any disparities in the mental health  
7 outcomes of rural, minority, and other under-  
8 served populations.

9 (b) REPORT.—Not later than 5 years after the date  
10 of enactment of this Act, the Secretary of Health and  
11 Human Services shall submit to the Congress, and make  
12 publicly available, a report on the findings of research  
13 under this section.

14 **SEC. 432. RESEARCH ON THE HEALTH AND DEVELOPMENT**  
15 **EFFECTS OF MEDIA ON INFANTS, CHILDREN,**  
16 **AND ADOLESCENTS.**

17 Subpart 7 of part C of title IV of the Public Health  
18 Service Act (42 U.S.C. 285g et seq.) is amended by adding  
19 at the end the following:

20 **“SEC. 452H. RESEARCH ON THE HEALTH AND DEVELOP-**  
21 **MENT EFFECTS OF MEDIA ON INFANTS, CHIL-**  
22 **DREN, AND ADOLESCENTS.**

23 “(a) IN GENERAL.—The Director of the National In-  
24 stitutes of Health, in coordination with or acting through  
25 the Director of the Institute, shall conduct and support

1 research and related activities concerning the health and  
2 developmental effects of media on infants, children, and  
3 adolescents, which may include the positive and negative  
4 effects of exposure to and use of media, such as social  
5 media, applications, websites, television, motion pictures,  
6 artificial intelligence, mobile devices, computers, video  
7 games, virtual and augmented reality, and other media  
8 formats as they become available. Such research shall at-  
9 tempt to better understand the relationships between  
10 media and technology use and individual differences and  
11 characteristics of children and shall include longitudinally  
12 designed studies to assess the impact of media on youth  
13 over time. Such research shall include consideration of  
14 core areas of child and adolescent health and development  
15 including the following:

16           “(1) COGNITIVE.—The role and impact of  
17           media use and exposure in the development of chil-  
18           dren and adolescents within such cognitive areas as  
19           language development, executive functioning, atten-  
20           tion, creative problem solving skills, visual and spa-  
21           tial skills, literacy, critical thinking, and other learn-  
22           ing abilities, and the impact of early technology use  
23           on developmental trajectories.

24           “(2) PHYSICAL.—The role and impact of media  
25           use and exposure on children’s and adolescent’s

1 physical development and health behaviors, including  
2 diet, exercise, sleeping and eating routines, and  
3 other areas of physical development.

4 “(3) SOCIO-EMOTIONAL.—The role and impact  
5 of media use and exposure on children’s and adoles-  
6 cents’ social-emotional competencies, including self-  
7 awareness, self-regulation, social awareness, relation-  
8 ship skills, empathy, distress tolerance, perception of  
9 social cues, awareness of one’s relationship with the  
10 media, and decision-making, as well as outcomes  
11 such as violations of privacy, perpetration of or ex-  
12 posure to violence, bullying or other forms of aggres-  
13 sion, depression, anxiety, substance use, misuse or  
14 disorder, and suicidal ideation/behavior and self-  
15 harm.

16 “(b) DEVELOPING RESEARCH AGENDA.—The Direc-  
17 tor of the National Institutes of Health, in consultation  
18 with the Director of the Institute, other appropriate na-  
19 tional research institutes, academies, and centers, the  
20 Trans-NIH Pediatric Research Consortium, and non-Fed-  
21 eral experts as needed, shall develop a research agenda  
22 on the health and developmental effects of media on in-  
23 fants, children, and adolescents to inform research activi-  
24 ties under subsection (a). In developing such research  
25 agenda, the Director may use whatever means necessary

1 (such as scientific workshops and literature reviews) to as-  
2 sess current knowledge and research gaps in this area.

3 “(c) RESEARCH PROGRAM.—In coordination with the  
4 Institute and other national research institutes and cen-  
5 ters, and utilizing the National Institutes of Health’s pro-  
6 cess of scientific peer review, the Director of the National  
7 Institutes of Health shall fund an expanded research pro-  
8 gram on the health and developmental effects of media  
9 on infants, children, and adolescents.

10 “(d) REPORT TO CONGRESS.—Not later than 1 year  
11 after the date of enactment of this Act, the Director of  
12 the National Institutes of Health shall submit a report to  
13 Congress on the progress made in gathering data and ex-  
14 panding research on the health and developmental effects  
15 of media on infants, children, and adolescents in accord-  
16 ance with this section. Such report shall summarize the  
17 grants and research funded, by year, under this section.”.

At the end of the bill, add the following new titles:

1     **TITLE V—MEDICAID AND CHIP**

2     **SEC. 501. MEDICAID AND CHIP REQUIREMENTS FOR**  
3                   **HEALTH SCREENINGS AND REFERRALS FOR**  
4                   **ELIGIBLE JUVENILES IN PUBLIC INSTITU-**  
5                   **TIONS.**

6           (a) MEDICAID STATE PLAN REQUIREMENT.—Section  
7 1902 of the Social Security Act (42 U.S.C. 1396a) is  
8 amended—

9           (1) in subsection (a)(84)—

10                   (A) in subparagraph (A), by inserting “,  
11 subject to subparagraph (D),” after “but”;

12                   (B) in subparagraph (B), by striking  
13 “and” at the end;

14                   (C) in subparagraph (C), by adding “and”  
15 at the end; and

16                   (D) by adding at the end the following new  
17 subparagraph:

18                   “(D) beginning on the first day of the first  
19 calendar quarter that begins two years after the  
20 date of enactment of this subparagraph, in the  
21 case of individuals who are eligible juveniles de-  
22 scribed in subsection (nn)(2), are within 30  
23 days of the date on which such eligible juvenile  
24 is scheduled to be released from a public insti-  
25 tution following adjudication, the State shall

1           have in place a plan to ensure, and in accord-  
2           ance with such plan, provide—

3                   “(i) for, in the 30 days prior to the  
4                   release of such an eligible juvenile from  
5                   such public institution (or not later than  
6                   one week after release from the public in-  
7                   stitution), and in coordination with such  
8                   institution—

9                           “(I) any screening or diagnostic  
10                           service which meets reasonable stand-  
11                           ards of medical and dental practice,  
12                           as determined by the State, or as in-  
13                           dicated as medically necessary, in ac-  
14                           cordance with paragraphs (1)(A) and  
15                           (5) of section 1905(r); and

16                           “(II) a mental health or other be-  
17                           havioral health screening that is a  
18                           screening service described under sec-  
19                           tion 1905(r)(1), or a diagnostic serv-  
20                           ice described under paragraph (5) of  
21                           such section, if such screening or di-  
22                           agnostic service was not otherwise  
23                           conducted pursuant to this clause;

24                           “(ii) for, not later than one week after  
25                           release from the public institution, refer-

1 rals for such eligible juvenile to the appro-  
2 priate care and services available under the  
3 State plan (or waiver of such plan) in the  
4 geographic region of the home or residence  
5 of such eligible juvenile, based on such  
6 screenings; and

7 “(iii) for, following the release of such  
8 eligible juvenile from such institution, not  
9 less than 30 days of targeted case manage-  
10 ment services furnished by a provider in  
11 the geographic region of the home or resi-  
12 dence of such eligible juvenile.”; and

13 (2) in subsection (nn)(3), by striking “(30)”  
14 and inserting “(31)”.

15 (b) AUTHORIZATION OF FEDERAL FINANCIAL PAR-  
16 TICIPATION.—The subdivision (A) of section 1905(a) of  
17 the Social Security Act (42 U.S.C. 1396d(a)) following  
18 paragraph (31) of such section is amended by inserting  
19 “, or in the case of an eligible juvenile described in section  
20 1902(a)(84)(D) with respect to the screenings, diagnostic  
21 services, referrals, and case management required under  
22 such subparagraph (D)” after “(except as a patient in a  
23 medical institution”.

24 (c) CHIP CONFORMING AMENDMENTS.—

1           (1) Section 2103(c) of the Social Security Act  
2           (42 U.S.C. 1397cc(c)) is amended by adding at the  
3           end the following new paragraph:

4           “(12) REQUIRED COVERAGE OF SCREENINGS,  
5           DIAGNOSTIC SERVICES, REFERRALS, AND CASE MAN-  
6           AGEMENT FOR CERTAIN INMATES PRE-RELEASE.—  
7           With respect to individuals described in section  
8           2110(b)(7), the State shall provide screenings, diag-  
9           nostic services, referrals, and case management oth-  
10          erwise covered under the State child health plan (or  
11          waiver of such plan) during the period described in  
12          such section with respect to such screenings, serv-  
13          ices, referrals, and case management.”.

14          (2) Section 2110(b) of the Social Security Act  
15          (42 U.S.C. 1397jj(b)) is amended—

16                 (A) in paragraph (2)(A), by inserting “ex-  
17                 cept as provided in paragraph (7),” before “a  
18                 child who is an inmate of a public institution”;  
19                 and

20                 (B) by adding at the end the following new  
21                 paragraph:

22                 “(7) EXCEPTION TO EXCLUSION OF CHILDREN  
23                 WHO ARE INMATES OF A PUBLIC INSTITUTION.—A  
24                 child shall not be considered to be described in para-  
25                 graph (2)(A) if such child is an eligible juvenile (as



1 described in section 1902(a)(84)(D)) with respect to  
2 the screenings, diagnostic services, referrals, and  
3 case management otherwise covered under the State  
4 child health plan (or waiver of such plan) during the  
5 period with respect to which such screenings, serv-  
6 ices, referrals, and case management is respectively  
7 required under such section.”.

8 **SEC. 502. GUIDANCE ON REDUCING ADMINISTRATIVE BAR-**  
9 **RIERS TO PROVIDING HEALTH CARE SERV-**  
10 **ICES IN SCHOOLS.**

11 (a) IN GENERAL.—Not later than 12 months after  
12 the date of enactment of this Act, the Secretary of Health  
13 and Human Services shall issue guidance to State Med-  
14 icaid agencies, elementary and secondary schools, and  
15 school-based health centers on reducing administrative  
16 barriers to such schools and centers furnishing medical as-  
17 sistance and obtaining payment for such assistance under  
18 titles XIX and XXI of the Social Security Act (42 U.S.C.  
19 1396 et seq., 1397aa et seq.).

20 (b) CONTENTS OF GUIDANCE.—The guidance issued  
21 pursuant to subsection (a) shall—

22 (1) include revisions to the May 2003 Medicaid  
23 School-Based Administrative Claiming Guide, the  
24 1997 Medicaid and Schools Technical Assistance

1 Guide, and other relevant guidance in effect on the  
2 date of enactment of this Act;

3 (2) provide information on payment under titles  
4 XIX and XXI of the Social Security Act (42 U.S.C.  
5 1396 et seq., 1397aa et seq.) for the provision of  
6 medical assistance, including such assistance pro-  
7 vided in accordance with an individualized education  
8 program or under the policy described in the State  
9 Medicaid Director letter on payment for services  
10 issued on December 15, 2014 (#14-006);

11 (3) take into account reasons why small and  
12 rural local education agencies may not provide med-  
13 ical assistance and provide information on best prac-  
14 tices to encourage such agencies to provide such as-  
15 sistance; and

16 (4) include best practices and examples of  
17 methods that State Medicaid agencies and local edu-  
18 cation agencies have used to pay for, and increase  
19 the availability of, medical assistance.

20 (c) DEFINITIONS.—In this Act:

21 (1) INDIVIDUALIZED EDUCATION PROGRAM.—  
22 The term “individualized education program” has  
23 the meaning given such term in section 602(14) of  
24 the Individuals with Disabilities Education Act (20  
25 U.S.C. 1401(14)).

1           (2) SCHOOL-BASED HEALTH CENTER.—The  
2           term “school-based health center” has the meaning  
3           given such term in section 2110(c)(9) of the Social  
4           Security Act (42 U.S.C. 1397jj(c)(9)), and includes  
5           an entity that provides Medicaid-covered services in  
6           school-based settings for which Federal financial  
7           participation is permitted.

8   **SEC. 503. GUIDANCE TO STATES ON SUPPORTING PEDI-**  
9                   **ATRIC BEHAVIORAL HEALTH SERVICES**  
10                   **UNDER MEDICAID AND CHIP.**

11           Not later than 18 months after the date of enactment  
12           of this Act, the Secretary of Health and Human Services  
13           shall issue guidance to States on how to expand the provi-  
14           sion of, and access to, behavioral health services, including  
15           mental health services, for children covered under State  
16           plans (or waivers of such plans) under title XIX of the  
17           Social Security Act (42 U.S.C. 1396 et seq.), or State  
18           child health plans (or waivers of such plans) under title  
19           XXI of such Act (42 U.S.C. 1397aa et seq.), including  
20           a description of best practices for—

- 21                   (1) expanding access to such services;  
22                   (2) expanding access to such services in under-  
23           served communities;

1           (3) flexibilities that States may offer for pedi-  
2           atric hospitals and other pediatric behavioral health  
3           providers to expand access to services; and

4           (4) recruitment and retention of providers of  
5           such services.

6   **SEC. 504. ENSURING CHILDREN RECEIVE TIMELY ACCESS**  
7                           **TO CARE.**

8           (a) **GUIDANCE TO STATES ON FLEXIBILITIES TO EN-**  
9           **SURE PROVIDER CAPACITY TO PROVIDE PEDIATRIC BE-**  
10          **HAVORAL HEALTH, INCLUDING MENTAL HEALTH, CRI-**  
11          **SIS CARE.**—Not later than 18 months after the date of  
12          enactment of this Act, the Secretary of Health and  
13          Human Services shall provide guidance to States on exist-  
14          ing flexibilities under State plans (or waivers of such  
15          plans) under title XIX of the Social Security Act (42  
16          U.S.C. 1396 et seq.), or State child health plans under  
17          title XXI of such Act (42 U.S.C. 1397aa et seq.), to sup-  
18          port children experiencing a behavioral health crisis or in  
19          need of intensive behavioral health, including mental  
20          health, services.

21          (b) **ENSURING CONSISTENT REVIEW AND STATE IM-**  
22          **PLEMENTATION OF EARLY AND PERIODIC SCREENING,**  
23          **DIAGNOSTIC, AND TREATMENT SERVICES.**—Section  
24          1905(r) of the Social Security Act (42 U.S.C. 1396d(r))  
25          is amended by adding at the end the following: “Not later

1 than January 1, 2025, and every 5 years thereafter, the  
2 Secretary shall review implementation of the requirements  
3 of this subsection by States, including such requirements  
4 relating to services provided by managed care organiza-  
5 tions, prepaid inpatient health plans, prepaid ambulatory  
6 health plans, and primary care case managers, to identify  
7 and disseminate best practices for ensuring comprehensive  
8 coverage of services, to identify gaps and deficiencies in  
9 meeting Federal requirements, and to provide guidance to  
10 States on addressing identified gaps and disparities and  
11 meeting Federal coverage requirements in order to ensure  
12 children have access to health services.”.

13 **SEC. 505. STRATEGIES TO INCREASE ACCESS TO TELE-**  
14 **HEALTH UNDER MEDICAID AND CHIP.**

15 Not later than 1 year after the date of the enactment  
16 of this Act, and in the event updates are available, once  
17 every five years thereafter, the Secretary of Health and  
18 Human Services shall update guidance issued by the Cen-  
19 ters for Medicare & Medicaid Services to States, the State  
20 Medicaid & CHIP Telehealth Toolkit, or any successor  
21 guidance, to describe strategies States may use to over-  
22 come existing barriers and increase access to telehealth  
23 services under the Medicaid program under title XIX of  
24 the Social Security Act (42 U.S.C. 1396 et seq.) and the  
25 Children’s Health Insurance Program under title XXI of

1 such Act (42 U.S.C. 1397aa et seq.). Such updated guid-  
2 ance shall include examples of and promising practices re-  
3 garding—

4 (1) telehealth delivery of covered services;

5 (2) recommended voluntary billing codes, modi-  
6 fiers, and place-of-service designations for telehealth  
7 and other virtual health care services;

8 (3) strategies States can use for the simplifica-  
9 tion or alignment of provider credentialing and en-  
10 rollment protocols with respect to telehealth across  
11 States, State Medicaid plans under title XIX, State  
12 child health plans under title XXI, Medicaid man-  
13 aged care organizations, prepaid inpatient health  
14 plans, prepaid ambulatory health plans, and primary  
15 care case managers, including during national public  
16 health emergencies; and

17 (4) strategies States can use to integrate tele-  
18 health and other virtual health care services into  
19 value-based health care models.

20 **SEC. 506. REMOVAL OF LIMITATIONS ON FEDERAL FINAN-**  
21 **CIAL PARTICIPATION FOR INMATES WHO ARE**  
22 **ELIGIBLE JUVENILES PENDING DISPOSITION**  
23 **OF CHARGES.**

24 (a) MEDICAID.—

1           (1) IN GENERAL.—The subdivision (A) of sec-  
2           tion 1905(a) of the Social Security Act (42 U.S.C.  
3           1396d(a)) following paragraph (31) of such section,  
4           as amended by section 501(b), is further amended  
5           by inserting “, or, at the option of the State, for an  
6           individual who is an eligible juvenile (as defined in  
7           section 1902(nn)(2)), while such individual is an in-  
8           mate of a public institution (as defined in section  
9           1902(nn)(3)) pending disposition of charges” after  
10          “or in the case of an eligible juvenile described in  
11          section 1902(a)(84)(D) with respect to the  
12          screenings, diagnostic services, referrals, and case  
13          management required under such subparagraph  
14          (D)”.

15          (2) CONFORMING.—Section 1902(a)(84)(A) of  
16          the Social Security Act (42 U.S.C. 1396a(a)(84)(A))  
17          is amended by inserting “(or in the case of a State  
18          electing the option described in the subdivision (A)  
19          following paragraph (31) of section 1905(a), during  
20          such period beginning after the disposition of  
21          charges with respect to such individual)” after “is  
22          such an inmate”.

23          (b) CHIP.—Section 2110(b)(7) of the Social Security  
24          Act (42 U.S.C. 13977jj(b)(7)), as added by section  
25          501(c)(2)(B), is further amended by inserting “or, at the

1 option of the State, for an individual who is a juvenile,  
2 while such individual is an inmate of a public institution  
3 pending disposition of charges” after “if such child is an  
4 eligible juvenile (as described in section 1902(a)(84)(D))  
5 with respect to screenings, diagnostic services, referrals,  
6 and case management otherwise covered under the State  
7 child health plan (or waiver of such plan)”.

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall take effect on the first day of the first  
10 calendar quarter that begins after the date that is 18  
11 months after the date of enactment of this Act and shall  
12 apply to items and services furnished for periods beginning  
13 on or after such date.

## 14 **TITLE VI—MISCELLANEOUS** 15 **PROVISIONS**

### 16 **SEC. 601. DETERMINATION OF BUDGETARY EFFECTS.**

17 The budgetary effects of this Act, for the purpose of  
18 complying with the Statutory Pay-As-You-Go Act of 2010,  
19 shall be determined by reference to the latest statement  
20 titled “Budgetary Effects of PAYGO Legislation” for this  
21 Act, submitted for printing in the Congressional Record  
22 by the Chairman of the House Budget Committee, pro-  
23 vided that such statement has been submitted prior to the  
24 vote on passage.



1 **SEC. 602. OVERSIGHT OF PHARMACY BENEFIT MANAGER**  
2 **SERVICES.**

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

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

7 **“SEC. 2799A–11. OVERSIGHT OF PHARMACY BENEFIT MAN-**  
8 **AGER SERVICES.**

9 “(a) IN GENERAL.—For plan years beginning on or  
10 after January 1, 2024, a group health plan or health in-  
11 surance issuer offering group health insurance coverage  
12 or an entity or subsidiary providing pharmacy benefits  
13 management services on behalf of such a plan or issuer  
14 shall not enter into a contract with a drug manufacturer,  
15 distributor, wholesaler, subcontractor, rebate aggregator,  
16 or any associated third party that limits the disclosure of  
17 information to plan sponsors in such a manner that pre-  
18 vents the plan or issuer, or an entity or subsidiary pro-  
19 viding pharmacy benefits management services on behalf  
20 of a plan or issuer, from making the reports described in  
21 subsection (b).

22 “(b) REPORTS.—

23 “(1) IN GENERAL.—For plan years beginning  
24 on or after January 1, 2024, not less frequently  
25 than once every 6 months, a health insurance issuer  
26 offering group health insurance coverage or an enti-

1 ty providing pharmacy benefits management services  
2 on behalf of a group health plan or an issuer pro-  
3 viding group health insurance coverage shall submit  
4 to the plan sponsor (as defined in section 3(16)(B)  
5 of the Employee Retirement Income Security Act of  
6 1974) of such group health plan or health insurance  
7 coverage a report in accordance with this subsection  
8 and make such report available to the plan sponsor  
9 in a machine-readable format. Each such report  
10 shall include, with respect to the applicable group  
11 health plan or health insurance coverage—

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

19 “(B) a list of each drug covered by such  
20 plan, issuer, or entity providing pharmacy ben-  
21 efit management services that was dispensed  
22 during the reporting period, including, with re-  
23 spect to each such drug during the reporting  
24 period—

1           “(i) the brand name, chemical entity,  
2           and National Drug Code;

3           “(ii) the number of participants and  
4           beneficiaries for whom the drug was filled  
5           during the plan year, the total number of  
6           prescription fills for the drug (including  
7           original prescriptions and refills), and the  
8           total number of dosage units of the drug  
9           dispensed across the plan year, including  
10          whether the dispensing channel was by re-  
11          tail, mail order, or specialty pharmacy;

12          “(iii) the wholesale acquisition cost,  
13          listed as cost per days supply and cost per  
14          pill, or in the case of a drug in another  
15          form, per dose;

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

21          “(v) for any drug for which gross  
22          spending of the group health plan or  
23          health insurance coverage exceeded  
24          \$10,000 during the reporting period—

1                   “(I) a list of all other drugs in  
2                   the same therapeutic category or  
3                   class, including brand name drugs  
4                   and biological products and generic  
5                   drugs or biosimilar biological products  
6                   that are in the same therapeutic cat-  
7                   egory or class as such drug; and

8                   “(II) the rationale for preferred  
9                   formulary placement of such drug in  
10                  that therapeutic category or class, if  
11                  applicable;

12                  “(C) a list of each therapeutic category or  
13                  class of drugs that were dispensed under the  
14                  health plan or health insurance coverage during  
15                  the reporting period, and, with respect to each  
16                  such therapeutic category or class of drugs,  
17                  during the reporting period—

18                         “(i) total gross spending by the plan,  
19                         before manufacturer rebates, fees, or other  
20                         manufacturer remuneration;

21                         “(ii) the number of participants and  
22                         beneficiaries who filled a prescription for a  
23                         drug in that category or class;

24                         “(iii) if applicable to that category or  
25                         class, a description of the formulary tiers

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

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

9 “(v) for each therapeutic category or  
10 class under which 3 or more drugs are in-  
11 cluded on the formulary of such plan or  
12 coverage—

13 “(I) the amount received, or ex-  
14 pected to be received, from drug man-  
15 ufacturers in rebates, fees, alternative  
16 discounts, or other remuneration—

17 “(aa) that has been paid, or  
18 is to be paid, by drug manufac-  
19 turers for claims incurred during  
20 the reporting period; or

21 “(bb) that is related to utili-  
22 zation of drugs, in such thera-  
23 peutic category or class;

24 “(II) the total net spending, after  
25 deducting rebates, price concessions,

1 alternative discounts or other remuneration from drug manufacturers, by  
2 the health plan or health insurance  
3 coverage on that category or class of  
4 drugs; and

5  
6 “(III) the net price per course of  
7 treatment or single fill, such as a 30-  
8 day supply or 90-day supply, incurred  
9 by the health plan or health insurance  
10 coverage and its participants and  
11 beneficiaries, after manufacturer re-  
12 bates, fees, and other remuneration  
13 for drugs dispensed within such thera-  
14 peutic category or class during the re-  
15 porting period;

16 “(D) total gross spending on prescription  
17 drugs by the plan or coverage during the re-  
18 porting period, before rebates and other manu-  
19 facturer fees or remuneration;

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

1           lated to utilization of drug or drug spending  
2           under that health plan or health insurance cov-  
3           erage during the reporting period;

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

7           “(G) amounts paid directly or indirectly in  
8           rebates, fees, or any other type of remuneration  
9           to brokers, consultants, advisors, or any other  
10          individual or firm who referred the group health  
11          plan’s or health insurance issuer’s business to  
12          the pharmacy benefit manager.

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

24          “(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, or applicable  
20          State agencies.

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



1           participants in the drug supply chain, in order to  
2           prevent anti-competitive behavior.

3           “(4) REPORT TO GAO.—A health insurance  
4           issuer offering group health insurance coverage or  
5           an entity providing pharmacy benefits management  
6           services on behalf of a group health plan shall sub-  
7           mit to the Comptroller General of the United States  
8           each of the first 4 reports submitted to a plan spon-  
9           sor under paragraph (1) with respect to such cov-  
10          erage or plan, and other such reports as requested,  
11          in accordance with the privacy requirements under  
12          paragraph (2), the disclosure and redisclosure stand-  
13          ards under paragraph (3), the standards specified  
14          pursuant to paragraph (5), and such other informa-  
15          tion that the Comptroller General determines nec-  
16          essary to carry out the study under section 602(d)  
17          of the Restoring Hope for Mental Health and Well-  
18          Being Act of 2022.

19          “(5) STANDARD FORMAT.—Not later than June  
20          1, 2023, the Secretary shall specify through rule-  
21          making standards for health insurance issuers and  
22          entities required to submit reports under paragraph  
23          (4) to submit such reports in a standard format.

24          “(c) ENFORCEMENT.—

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

4           “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
5           TION.—A health insurance issuer or an entity pro-  
6           viding pharmacy benefit management services that  
7           violates subsection (a) or fails to provide information  
8           required under subsection (b), or a drug manufac-  
9           turer that fails to provide information under sub-  
10          section (b)(1)(A) in a timely manner, shall be sub-  
11          ject to a civil monetary penalty in the amount of  
12          \$10,000 for each day during which such violation  
13          continues or such information is not disclosed or re-  
14          ported.

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

23          “(4) PROCEDURE.—The provisions of section  
24          1128A of the Social Security Act, other than sub-  
25          section (a) and (b) and the first sentence of sub-

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

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

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

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 (b) 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 BENEFIT MANAGER**  
2 **SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or  
4 after January 1, 2024, a group health plan (or health in-  
5 surance issuer offering group health insurance coverage  
6 in connection with such a plan) or an entity or subsidiary  
7 providing pharmacy benefits management services on be-  
8 half of such a plan or issuer shall not enter into a contract  
9 with a drug manufacturer, distributor, wholesaler, subcon-  
10 tractor, rebate aggregator, or any associated third party  
11 that limits the disclosure of information to plan sponsors  
12 in such a manner that prevents the plan or issuer, or an  
13 entity or subsidiary providing pharmacy benefits manage-  
14 ment services on behalf of a plan or issuer, from making  
15 the reports described in subsection (b).

16 “(b) REPORTS.—

17 “(1) IN GENERAL.—For plan years beginning  
18 on or after January 1, 2024, not less frequently  
19 than once every 6 months, a health insurance issuer  
20 offering group health insurance coverage or an enti-  
21 ty providing pharmacy benefits management services  
22 on behalf of a group health plan or an issuer pro-  
23 viding group health insurance coverage shall submit  
24 to the plan sponsor (as defined in section 3(16)(B))  
25 of such group health plan or group health insurance  
26 coverage a report in accordance with this subsection

1 and make such report available to the plan sponsor  
2 in a machine-readable format. Each such report  
3 shall include, with respect to the applicable group  
4 health plan or health insurance coverage—

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 or coverage;

12 “(B) a list of each drug covered by such  
13 plan, issuer, or entity providing pharmacy ben-  
14 efit management services that was dispensed  
15 during the reporting period, including, with re-  
16 spect to each such drug during the reporting  
17 period—

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

20 “(ii) the number of participants and  
21 beneficiaries for whom the drug was filled  
22 during the plan year, the total number of  
23 prescription fills for the drug (including  
24 original prescriptions and refills), and the  
25 total number of dosage units of the drug

1 dispensed across the plan year, including  
2 whether the dispensing channel was by re-  
3 tail, mail order, or specialty 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 dose;

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

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 reporting period—

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 preferred  
25 formulary placement of such drug in

1                   that therapeutic category or class, if  
2                   applicable;

3                   “(C) a list of each therapeutic category or  
4                   class of drugs that were dispensed under the  
5                   health plan or health insurance coverage during  
6                   the reporting period, and, with respect to each  
7                   such therapeutic category or class of drugs,  
8                   during the reporting period—

9                   “(i) total gross spending by the plan,  
10                  before manufacturer rebates, fees, or other  
11                  manufacturer remuneration;

12                  “(ii) the number of participants and  
13                  beneficiaries who filled a prescription for a  
14                  drug in that category or class;

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

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



1                   “(v) for each therapeutic category or  
2                   class under which 3 or more drugs are in-  
3                   cluded on the formulary of such plan or  
4                   coverage—

5                   “(I) the amount received, or ex-  
6                   pected to be received, from drug man-  
7                   ufacturers in rebates, fees, alternative  
8                   discounts, or other remuneration—

9                   “(aa) that has been paid, or  
10                  is to be paid, by drug manufac-  
11                  turers for claims incurred during  
12                  the reporting period; or

13                  “(bb) that is related to utili-  
14                  zation of drugs, in such thera-  
15                  peutic category or class;

16                  “(II) the total net spending, after  
17                  deducting rebates, price concessions,  
18                  alternative discounts or other remu-  
19                  neration from drug manufacturers, by  
20                  the health plan or health insurance  
21                  coverage on that category or class of  
22                  drugs; and

23                  “(III) the net price per course of  
24                  treatment or single fill, such as a 30-  
25                  day supply or 90-day supply, incurred

1 by the health plan or health insurance  
2 coverage and its participants and  
3 beneficiaries, after manufacturer re-  
4 bates, fees, and other remuneration  
5 for drugs dispensed within such thera-  
6 peutic category or class during the re-  
7 porting period;

8 “(D) total gross spending on prescription  
9 drugs by the plan or coverage during the re-  
10 porting period, before rebates and other manu-  
11 facturer fees or remuneration;

12 “(E) total amount received, or expected to  
13 be received, by the health plan or health insur-  
14 ance coverage in drug manufacturer rebates,  
15 fees, alternative discounts, and all other remu-  
16 nation received from the manufacturer or any  
17 third party, other than the plan sponsor, re-  
18 lated to utilization of drug or drug spending  
19 under that health plan or health insurance cov-  
20 erage during the reporting period;

21 “(F) the total net spending on prescription  
22 drugs by the health plan or health insurance  
23 coverage during the reporting period; and

24 “(G) amounts paid directly or indirectly in  
25 rebates, fees, or any other type of remuneration

1 to brokers, consultants, advisors, or any other  
2 individual or firm who referred the group health  
3 plan's or health insurance issuer's business to  
4 the pharmacy benefit manager.

5 “(2) PRIVACY REQUIREMENTS.—Health insur-  
6 ance issuers offering group health insurance cov-  
7 erage and entities providing pharmacy benefits man-  
8 agement services on behalf of a group health plan  
9 shall provide information under paragraph (1) in a  
10 manner consistent with the privacy, security, and  
11 breach notification regulations promulgated under  
12 section 264(c) of the Health Insurance Portability  
13 and Accountability Act of 1996, and shall restrict  
14 the use and disclosure of such information according  
15 to such privacy regulations.

16 “(3) DISCLOSURE AND REDISCLOSURE.—

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

23 “(B) CLARIFICATION REGARDING PUBLIC  
24 DISCLOSURE OF INFORMATION.—Nothing in  
25 this section prevents a health insurance issuer

1 offering group health insurance coverage or an  
2 entity providing pharmacy benefits management  
3 services on behalf of a group health plan from  
4 placing reasonable restrictions on the public dis-  
5 closure of the information contained in a report  
6 described in paragraph (1), except that such  
7 issuer or entity may not restrict disclosure of  
8 such report to the Department of Health and  
9 Human Services, the Department of Labor, the  
10 Department of the Treasury, or applicable  
11 State agencies.

12 “(C) LIMITED FORM OF REPORT.—The  
13 Secretary shall define through rulemaking a  
14 limited form of the report under paragraph (1)  
15 required of plan sponsors who are drug manu-  
16 facturers, drug wholesalers, or other direct par-  
17 ticipants in the drug supply chain, in order to  
18 prevent anti-competitive behavior.

19 “(4) REPORT TO GAO.—A health insurance  
20 issuer offering group health insurance coverage or  
21 an entity providing pharmacy benefits management  
22 services on behalf of a group health plan shall sub-  
23 mit to the Comptroller General of the United States  
24 each of the first 4 reports submitted to a plan spon-  
25 sor under paragraph (1) with respect to such cov-

1 erage or plan, and other such reports as requested,  
2 in accordance with the privacy requirements under  
3 paragraph (2), the disclosure and redisclosure stand-  
4 ards under paragraph (3), the standards specified  
5 pursuant to paragraph (5), and such other informa-  
6 tion that the Comptroller General determines nec-  
7 essary to carry out the study under section 602(d)  
8 of the Restoring Hope for Mental Health and Well-  
9 Being Act of 2022.

10 “(5) STANDARD FORMAT.—Not later than June  
11 1, 2023, the Secretary shall specify through rule-  
12 making standards for health insurance issuers and  
13 entities required to submit reports under paragraph  
14 (4) to submit such reports in a standard format.

15 “(c) ENFORCEMENT.—

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

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

1 section (b)(1)(A) in a timely manner, shall be sub-  
2 ject to a civil monetary penalty in the amount of  
3 \$10,000 for each day during which such violation  
4 continues or such information is not disclosed or re-  
5 ported.

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

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

22 “(5) WAIVERS.—The Secretary may waive pen-  
23 alties under paragraph (2), or extend the period of  
24 time for compliance with a requirement of this sec-  
25 tion, for an entity in violation of this section that

1 has made a good-faith effort to comply with this sec-  
2 tion.

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

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

13 (B) in section 502(b)(3) (29 U.S.C.  
14 1132(b)(3)), by inserting “(other than section  
15 726)” after “part 7”.

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

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

21 (c) IRC.—

22 (1) IN GENERAL.—Subchapter B of chapter  
23 100 of the Internal Revenue Code of 1986 is amend-  
24 ed by adding at the end the following:

1 **“SEC. 9826. OVERSIGHT OF PHARMACY BENEFIT MANAGER**  
2 **SERVICES.**

3 “(a) IN GENERAL.—For plan years beginning on or  
4 after January 1, 2024, a group health plan or an entity  
5 or subsidiary providing pharmacy benefits management  
6 services on behalf of such a plan shall not enter into a  
7 contract with a drug manufacturer, distributor, whole-  
8 saler, subcontractor, rebate aggregator, or any associated  
9 third party that limits the disclosure of information to  
10 plan sponsors in such a manner that prevents the plan,  
11 or an entity or subsidiary providing pharmacy benefits  
12 management services on behalf of a plan, from making  
13 the reports described in subsection (b).

14 “(b) REPORTS.—

15 “(1) IN GENERAL.—For plan years beginning  
16 on or after January 1, 2024, not less frequently  
17 than once every 6 months, an entity providing phar-  
18 macy benefits management services on behalf of a  
19 group health plan shall submit to the plan sponsor  
20 (as defined in section 3(16)(B) of the Employee Re-  
21 tirement Income Security Act of 1974) of such  
22 group health plan a report in accordance with this  
23 subsection and make such report available to the  
24 plan sponsor in a machine-readable format. Each  
25 such report shall include, with respect to the applica-  
26 ble group health plan—



1           “(A) as applicable, information collected  
2           from drug manufacturers by such entity on the  
3           total amount of copayment assistance dollars  
4           paid, or copayment cards applied, that were  
5           funded by the drug manufacturer with respect  
6           to the participants and beneficiaries in such  
7           plan;

8           “(B) a list of each drug covered by such  
9           plan or entity providing pharmacy benefit man-  
10          agement services that was dispensed during the  
11          reporting period, including, with respect to each  
12          such drug during the reporting period—

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

15                 “(ii) the number of participants and  
16                 beneficiaries for whom the drug was filled  
17                 during the plan year, the total number of  
18                 prescription fills for the drug (including  
19                 original prescriptions and refills), and the  
20                 total number of dosage units of the drug  
21                 dispensed across the plan year, including  
22                 whether the dispensing channel was by re-  
23                 tail, mail order, or specialty 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 dose;

3 “(iv) the total out-of-pocket spending  
4 by participants and beneficiaries on such  
5 drug, including participant and beneficiary  
6 spending through copayments, coinsurance,  
7 and deductibles; and

8 “(v) for any drug for which gross  
9 spending of the group health plan exceeded  
10 \$10,000 during the reporting period—

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

18 “(II) the rationale for preferred  
19 formulary placement of such drug in  
20 that therapeutic category or class, if  
21 applicable;

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

1 with respect to each such therapeutic category  
2 or class of drugs, during the reporting period—

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 filled a prescription for a  
8 drug in that category or class;

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

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

19 “(v) for each therapeutic category or  
20 class under which 3 or more drugs are in-  
21 cluded on the formulary of such plan—

22 “(I) the amount received, or ex-  
23 pected to be received, from drug man-  
24 ufacturers in rebates, fees, alternative  
25 discounts, or other remuneration—

1                   “(aa) that has been paid, or  
2                   is to be paid, by drug manufac-  
3                   turers for claims incurred during  
4                   the reporting period; or

5                   “(bb) that is related to utili-  
6                   zation of drugs, in such thera-  
7                   peutic category or class;

8                   “(II) the total net spending, after  
9                   deducting rebates, price concessions,  
10                  alternative discounts or other remu-  
11                  neration from drug manufacturers, by  
12                  the health plan on that category or  
13                  class of drugs; and

14                  “(III) the net price per course of  
15                  treatment or single fill, such as a 30-  
16                  day supply or 90-day supply, incurred  
17                  by the health plan and its participants  
18                  and beneficiaries, after manufacturer  
19                  rebates, fees, and other remuneration  
20                  for drugs dispensed within such thera-  
21                  peutic category or class during the re-  
22                  porting period;

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

1 before rebates and other manufacturer fees or  
2 remuneration;

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

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

14 “(G) amounts paid directly or indirectly in  
15 rebates, fees, or any other type of remuneration  
16 to brokers, consultants, advisors, or any other  
17 individual or firm who referred the group health  
18 plan’s business to the pharmacy benefit man-  
19 ager.

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

1 Health Insurance Portability and Accountability Act  
2 of 1996, and shall restrict the use and disclosure of  
3 such information according to such privacy regula-  
4 tions.

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 an entity providing phar-  
15 macy benefits management services on behalf of  
16 a group health plan from placing reasonable re-  
17 strictions on the public disclosure of the infor-  
18 mation contained in a report described in para-  
19 graph (1), except that such entity may not re-  
20 strict disclosure of such report to the Depart-  
21 ment of Health and Human Services, the De-  
22 partment of Labor, the Department of the  
23 Treasury, or applicable State agencies.

24 “(C) LIMITED FORM OF REPORT.—The  
25 Secretary shall define through rulemaking a

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

6           “(4) REPORT TO GAO.—An entity providing  
7           pharmacy benefits management services on behalf of  
8           a group health plan shall submit to the Comptroller  
9           General of the United States each of the first 4 re-  
10          ports submitted to a plan sponsor under paragraph  
11          (1) with respect to such plan, and other such reports  
12          as requested, in accordance with the privacy require-  
13          ments under paragraph (2), the disclosure and re-  
14          disclosure standards under paragraph (3), the stand-  
15          ards specified pursuant to paragraph (5), and such  
16          other information that the Comptroller General de-  
17          termines necessary to carry out the study under sec-  
18          tion 602(d) of the Restoring Hope for Mental  
19          Health and Well-Being Act of 2022.

20          “(5) STANDARD FORMAT.—Not later than June  
21          1, 2023, the Secretary shall specify through rule-  
22          making standards for entities required to submit re-  
23          ports under paragraph (4) to submit such reports in  
24          a standard format.

25          “(c) ENFORCEMENT.—

1           “(1) IN GENERAL.—The Secretary, in consulta-  
2           tion with the Secretary of Labor and the Secretary  
3           of Health and Human Services, shall enforce this  
4           section.

5           “(2) FAILURE TO PROVIDE TIMELY INFORMA-  
6           TION.—An entity providing pharmacy benefit man-  
7           agement services that violates subsection (a) or fails  
8           to provide information required under subsection  
9           (b), or a drug manufacturer that fails to provide in-  
10          formation under subsection (b)(1)(A) in a timely  
11          manner, shall be subject to a civil monetary penalty  
12          in the amount of \$10,000 for each day during which  
13          such violation continues or such information is not  
14          disclosed or reported.

15          “(3) FALSE INFORMATION.—An entity pro-  
16          viding pharmacy benefit management services, or  
17          drug manufacturer that knowingly provides false in-  
18          formation under this section shall be subject to a  
19          civil money penalty in an amount not to exceed  
20          \$100,000 for each item of false information. Such  
21          civil money penalty shall be in addition to other pen-  
22          alties as may be prescribed by law.

23          “(4) PROCEDURE.—The provisions of section  
24          1128A of the Social Security Act, other than sub-  
25          section (a) and (b) and the first sentence of sub-



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

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

12 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-  
13 tion shall be construed to permit a group health plan or  
14 other entity to restrict disclosure to, or otherwise limit the  
15 access of, the Department of the Treasury to a report de-  
16 scribed in subsection (b)(1) or information related to com-  
17 pliance with subsection (a) by such plan or entity.

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

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

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

25 (d) GAO STUDY.—

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

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

17                   (B) as it relates to pharmacy networks  
18                   that include pharmacies under common owner-  
19                   ship described in subparagraph (A)—

20                           (i) whether such networks are de-  
21                           signed to encourage enrollees of a plan or  
22                           coverage to use such pharmacies over other  
23                           network pharmacies for specific services or  
24                           drugs, and if so, the reasons the networks

1 give for encouraging use of such phar-  
2 macies; and

3 (ii) whether such pharmacies are used  
4 by enrollees disproportionately more in the  
5 aggregate or for specific services or drugs  
6 compared to other network pharmacies;

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

15 (D) pharmacy network design parameters  
16 that encourage enrollees in the plan or coverage  
17 to fill prescriptions at mail order, specialty, or  
18 retail pharmacies that are wholly or partially-  
19 owned by that issuer or entity; and

20 (E) the degree to which mail order, spe-  
21 cialty, or retail pharmacies that dispense pre-  
22 scription drugs to an enrollee in a group health  
23 plan or health insurance coverage that are  
24 under common ownership (in whole or part)  
25 with group health plans, health insurance

1           issuers, or entities providing pharmacy benefit  
2           management services or pharmacy benefit ad-  
3           ministrative services under group health plan or  
4           group or individual health insurance coverage  
5           receive reimbursement that is greater than the  
6           median price charged to the group health plan  
7           or health insurance issuer when the same drug  
8           is dispensed to enrollees in the plan or coverage  
9           by other pharmacies included in the pharmacy  
10          network of that plan, issuer, or entity that are  
11          not wholly or partially owned by the health in-  
12          surance issuer or entity providing pharmacy  
13          benefit management services.

14           (2) REQUIREMENT.—The Comptroller General  
15          of the United States shall ensure that the report  
16          under paragraph (1) does not contain information  
17          that would allow a reader to identify a specific plan  
18          or entity providing pharmacy benefits management  
19          services or otherwise contain commercial or financial  
20          information that is privileged or confidential.

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

1 **SEC. 603. MEDICARE IMPROVEMENT FUND.**

2 Section 1898(b)(1) of the Social Security Act (42  
3 U.S.C. 1395iii(b)(1)) is amended by striking  
4 “\$5,000,000” and inserting “\$1,029,000,000”.

5 **SEC. 604. LIMITATIONS ON AUTHORITY.**

6 In carrying out any program of the Substance Abuse  
7 and Mental Health Services Administration whose statu-  
8 tory authorization is enacted or amended by this Act, the  
9 Secretary of Health and Human Services shall not allocate  
10 funding, or require award recipients to prioritize, dedicate,  
11 or allocate funding, without consideration of the incidence,  
12 prevalence, or determinants of mental health or substance  
13 use issues, unless such allocation or requirement is con-  
14 sistent with statute, regulation, or other Federal law.

