House Committee Transparency Legislation – Drug/Pharmacy Policies

September 15, 2023

The leaders of the three House Committees with jurisdiction over hospital and insurer price transparency reached agreement on the text of a new bill late last week.

- Click here for H.R. 5388, the Lower Costs, More Transparency Act, here for the Committees' section-by-section and here for the press release.

In addition to the provisions impacting hospitals, there are several targeting drug and pharmacy policies including PBMs. Key provisions include –

- *Section 106, Pharmacy Benefits Managers Transparency*
  - Requires health plans and PBMs to provide a report at least every six months to plan sponsors (i.e. employers) a report that includes the following (the bill covers all health plans including ERISA):
    - brand name, chemical entity, and National Drug Code;
    - type of dispenser, i.e. retail, mail order, or specialty pharmacy;
    - whether the drug is generic or brand name along with the cost;
    - total number of prescription claims including refills along with dosages and days of supply and the net price, after manufacturer rebates, fees, and other adjustments;
    - total amount of out-of-pocket spending by patients including through copayments, coinsurance, and deductibles;
    - total amount of rebates and discounts received by third parties such as GPOs;
    - total amount rebates or discounts received or expected from drug manufacturers;
    - information on copayment assistance or other discounts patients received from drug manufacturers;
    - breakdown of total gross spending on drugs before rebates or discounts;
    - amounts paid to brokers, consultants, advisors, or any other individual or firm, for referral of the group health plan's or health insurance issuer's business to an entity providing PBM services; and
    - explanation of mail order, specialty, or retail pharmacy requirements along with the breakdown of the total percentage of drugs filled at these entities.

  - GAO Reports – Each plan will be required to submit to the GAO each of the first 4 reports submitted to an employer and any other reports as requested and such other information that the GAO to carryout a study under the legislation. Failure to provide the required reports could lead to fines up to $10,000 per day, and false information in the reports are subject to up to $100,000 per false statement.

    - Pharmacy Network Design – Three years after enactment, GAO will submit a report to Congress a report on pharmacy networks' design, parameters, and management services based off information that plans are required to report to plan sponsors.
    - Co-Pay Assistance Programs – Eighteen months after enactment GAO will submit a report to Congress on what is known about the role of copay assistance programs and the impact of such programs 19 on commercial health insurance, stop loss, and drug prices.

- *Section 108 – Report on Integration in Medicare*
    - Under this section, Medicare Advantage organizations (MAO) are required to report to HHS certain information relating to health care providers, PBMs, and pharmacies with which they share common ownership. It also requires MedPAC to study and report on vertical integration between MAO, health care providers, PBMs, and pharmacies and how this integration impacts beneficiary access, cost, quality, and outcomes.
        - Under this section, Part D plans offering a prescription drug plans must report to HHS ownership information on designated pharmacies within plans such as if the pharmacy is owned by the PBM.
        - The MedPAC report on vertical integration within MAOs must also include prescription drug plan sponsors and PBMs with analysis of the impact of such integration on access, price, quality, and outcomes. The report must make certain comparisons to prescription drug plans, review physician-administered drugs, and affiliated pharmacies.

- *Section 202 – Improving Transparency and Preventing the Use of Abusive Spread Pricing and Related Practices in Medicaid*
    - Would ban PBMs that contract with Medicaid Managed Care Organizations from utilizing spread pricing when a PBM charges health plans for prescriptions more than they pay the pharmacy for the drug.
        - The section would require that reimbursement would be the cost of the drug plus an administration fee.
        - 340B drugs are exempt from this policy, allowing for State policies on the program.
        - Pharmacies will be required to complete a survey and report actual acquisition costs of drugs for those purchased under Medicaid Managed Care Organizations.

- *Section 203 – Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus*
    - Requires site-neutral payments for physician-administered drugs under Medicare which will require HOPDs to be paid the same as physician offices.

- *Section 402 – Hidden Fees Disclosure Requirements*
    - Increases requirements on PBMs and third party administrators on disclosures of fees and other requirements associated with health plan fiduciaries.

- *Section 403 – Prescription Drug Price Information Requirement*
    - Clarifies that pharmacy gag clauses are banned for all private health plans.