DESCRIPTION OF THE TAX PROVISIONS OF H.R. 4822, THE "HEALTH CARE PRICE TRANSPARENCY ACT OF 2023"

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
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INTRODUCTION

The House Committee on Ways and Means has scheduled for July 26, 2023, a markup of H.R. 4822, the "Health Care Price Transparency Act of 2023." This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the tax provisions of the bill.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of the Tax Provisions of H.R. 4822, the "Health Care Price Transparency Act of 2023"* (JCX-36-23), July 24, 2023. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references in the document are to the Internal Revenue Code of 1986, as amended (the "Code"), unless otherwise stated.

A. Promoting Group Health Plan Price Transparency

Present Law

Under the Patient Protection and Affordable Care Act ("PPACA"),[2] individual market health insurance coverage must meet various requirements to qualify for certification to be offered through an Exchange ("Exchange coverage").[3] Among these requirements, Exchange coverage must permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an internet website and such other means for individuals without access to the internet.[4]

This transparency requirement also applies to group health plans and to health insurance issuers offering group or individual health insurance coverage.[5]

In 2020, the Department of the Treasury, Department of Labor, and Department of Health and Human Services ("HHS") (collectively, "the Departments") adopted final rules under the authority described above imposing additional transparency requirements on group health plans and health insurance issuers, [6] the Transparency in Coverage Final Rules ("TiC Final Rules").[7]

The TiC Final Rules require group health plans to make the information described below available in the formats described below.[8]

Self-service tool

Group health plans must make available to participants and beneficiaries a "self-service tool" that provides estimated cost-sharing information for a covered item or service from a

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[2] Pub. L. No. 111-148, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, March 30, 2010.

[3] An Exchange is established under section 1311 of the PPACA.

[4] Sec. 1311(e)(3)(C) of the PPACA. These requirements do not apply to grandfathered coverage as provided under section 1251 of the PPACA.

[5] Sec. 2715A of the Public Health Service Act ("PHSA"); sec. 9815.

[6] The Departments cooperate on implementing analogous requirements applicable to both group health plans and health insurance issuers under their respective authorities. The Code, however, applies these requirements only to group health plans, see section 9801 *et seq.* Therefore, for simplicity, this document generally refers only to "group health plans" or "plans."

[7] T.D. 9929, 85 Fed. Reg. 72158, Nov. 12, 2020.

[8] These requirements do not apply to health reimbursement arrangements or other account-based plans.

particular provider or providers.[9] The self-service tool must be available over the internet, and group health plans must make the required information available in paper form,[10] upon request.

Plans are required to make the following information available:

- An estimate of the participant's or beneficiary's cost-sharing liability for a requested covered item or service;[11]
- Accumulated amounts;[12]
- The in-network rate for the item or service;
- The out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount the plan will pay for the requested covered item or service, generally reflected as a dollar amount, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider;
- If applicable, notification that coverage of a specific item or service is subject to a prerequisite;
- A notice including specified plain language disclaimers.

This information must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request.

The tool must allow users to search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

- A billing code or a descriptive term, at the option of the user;
- The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and
- Other factors utilized by the plan that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

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[9] The information made available must include 500 specified items and services for plan years beginning on or after January 1, 2023, and all items and services for plan years beginning on or after January 1, 2024.

[10] The TiC Final Rules set forth detailed requirements for the use of the paper method.

[11] The TiC Final Rules also include detailed provisions regarding the reporting of information on bundled payment arrangements.

[12] Accumulated amounts are generally defined to mean the amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, with respect to a deductible or out-of-pocket limit.

The tool must allow users to search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount a plan will pay for a covered item or service provided by out-of-network providers by inputting:

- A billing code or descriptive term, at the option of the user; and
- Other factors utilized by the plan that are relevant for determining the applicable out-of-network allowed amount or other rate (such as the location in which the covered item or service will be sought or provided).

The tool must allow users to refine and reorder search results based on geographic proximity of in-network providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

The TiC Final Rules also include standards to prevent unnecessary duplication and permit a plan to satisfy these requirements by entering into a written agreement under which another party provides the required information, though the plan remains ultimately responsible for providing this information.

Machine-readable files

Group health plans must make publicly available three machine-readable files including price information for in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs. These files must be updated on a monthly basis.

The in-network rate machine-readable file must include the following information, with an exception for prescription drugs that are subject to a fee-for-service reimbursement arrangement, in addition to plan identifying information:

- A billing code and a plain language description for each billing code for each covered item or service;
- All applicable rates, including for bundled payment arrangements,[13] which must be:
    - Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each in-network provider.
    - Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

[13] If the plan does not use negotiated rates for provider reimbursement, then the plan should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the plan uses underlying fee schedule rates for calculating cost sharing, then the plan should include the underlying fee schedule rates in addition to the negotiated rate or derived amount.

- indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

The out-of-network allowed amount machine-readable file is required to include, in addition to plan identifying information:

- A billing code and a plain language description for each billing code for each covered item or service; and
- Unique out-of-network allowed amounts and billed charges with respect to covered items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that this data must be omitted in relation to a particular item or service and provider when inclusion would require the reporting of out-of-network allowed amounts in connection with fewer than 20 different claims for payments under a single plan). Each unique out-of-network allowed amount must be reflected as a dollar amount and associated with the NPI, TIN, and Place of Service Code for each out-of-network provider.

The prescription drug machine-readable file is required to include, in addition to plan identifying information:

- The National Drug Code ("NDC"), and the proprietary and nonproprietary name assigned to the NDC by the Food and Drug Administration (FDA), for each covered item or service under each coverage option offered by a plan that is a prescription drug;
- The negotiated rates, which must be:
  - Reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider;
  - Associated with the NPI, TIN, and Place of Service Code for each in-network provider; and
  - Associated with the last date of the contract term for each provider-specific negotiated rate that applies to each NDC;
- Historical net prices[14] that are:
  - Reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider;

[14] Historical net price means the retrospective average amount a plan paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees, and any additional price concessions received by the plan with respect to the prescription drug.

- Associated with the NPI, TIN, and Place of Service Code for each in-network provider; and

- Associated with the 90-day time period that begins 180 days prior to the publication date of the machine-readable file for each provider-specific historical net price that applies to each NDC (except that such data must be omitted in relation to a particular NDC and provider when inclusion would require the reporting of historical net prices calculated using fewer than 20 different claims for payment).

The machine-readable files must be available in a form and manner as specified in guidance issued by the Departments. The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

The TiC Final Rules include standards to prevent unnecessary duplication and permit plans to satisfy these requirements by entering into a written agreement under which another party provides the required information, though the plan remains ultimately responsible for providing this information.

In addition, plans may satisfy the allowed amount file requirement by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an issuer, a service provider, or other party with which the plan has entered into a written agreement to provide the information, provided the minimum claim threshold described above is independently met for each item or service and for each plan included in an aggregated file. Under such circumstances, health insurance issuers, service providers, or other parties with which the plan has contracted may aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract.

Subsequent changes in law and guidance

The Consolidated Appropriations Act, 2021 ("2021 CAA"),[15] also includes transparency requirements. The 2021 CAA requires group health plans and health insurance issuers to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that (to the extent practicable) allows an individual enrolled under the plan or coverage, with respect to participating providers, to compare the amount of cost-sharing for which the individual would be responsible under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.[16]

[15] Pub. L. No. 116-260, December 27, 2020.

[16] Sec. 9819, sec. 719 of the Employee Retirement Income Security Act ("ERISA"), and sec. 2799A-4 of the PHSA, as added by section 114 of division BB of the 2021 CAA. These provisions apply to health plans that are grandfathered under section 1251 of the PPACA, unlike the requirements of section 1311 of the PPACA.

In addition, the 2021 CAA includes reporting requirements primarily related to prescription drug expenditures, requiring that plans and issuers submit detailed information to the Departments regarding prescription drug coverage, including, for example, the 50 most frequently dispensed brand prescription drugs, and the total number of paid claims for each such drug; the 50 most costly prescription drugs by total annual spending, and the annual amount spent by the plan or coverage for each such drug; and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.[17] Additionally, the 2021 CAA requires the Departments to issue biannual public reports on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the impact of prescription costs on premium rates.

Based on the rationale that the price comparison guidance required by the 2021 CAA is largely duplicative of the internet-based self-service tool requirement of the TiC Final Rules (with the exception of the requirement in the 2021 CAA that information be available by telephone), the Departments indicated in guidance that they intend to propose rulemaking regarding whether compliance with the internet-based self-service tool requirements of the TiC Final Rules satisfies the similar requirements set forth in the 2021 CAA.[18] In addition, the Departments stated that they intend to propose rulemaking requiring that the same pricing information that is available through the online tool or in paper form, as described in the TiC Final Rules, also be provided over the telephone upon request.

Finally, in response to the enactment of the drug price reporting provisions in the 2021 CAA and stakeholder concerns, the Departments announced they are deferring enforcement of the prescription drug machine-readable file requirement in the TiC Final Rules while they consider whether the prescription drug machine-readable file requirement remains appropriate.[19]

Description of Proposal

The proposal generally codifies the TiC Final Rules, with certain changes, in place of the 2021 CAA price comparison provision described above. In particular, the proposal requires group health plans to make the information described below available in the formats described below.

[17] See sec. 9825, sec. 725 of ERISA, and sec. 2799A-10 of the PHSA, as added by section 204 of division BB of the 2021 CAA.

[18] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, August 20, 2021, available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

[19] *Ibid.*

Self-service tool

A group health plan is required to permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a provider in a timely manner upon the request of the individual according to the parameters described below.

This disclosure must include the following specified information:

- If the provider is a participating provider with respect to the item or service, the in-network rate for such item or service;
- If the provider is not such a participating provider, the maximum allowed amount for the item or service;
- The estimated amount of cost-sharing (including deductibles, copayments, and coinsurance) that the participant or beneficiary will incur for the item or service, calculated, for providers that are not participating providers, using the maximum allowed amount;
- The amount the participant or beneficiary had already accumulated with respect to any deductible or out of pocket maximum, for participating and non-participating providers, broken down for separate individuals if separate deductibles or maximums apply to separate individuals under the plan, in addition to any cumulative amount;
- If the plan imposes any applicable frequency or volume limitations (excluding medical necessity determinations), the amount that the participant or beneficiary has accrued towards such limitation with respect to the item or service; and
- Any prior authorization, concurrent review, step therapy, fail first, or similar requirements applicable to the item or service.

The Secretary of the Treasury ("Secretary") is authorized to modify these requirements by providing that information described in any of the categories above not be treated as information required to be disclosed, and may designate additional information that must be disclosed, if determined appropriate by the Secretary.

The plan must make this information available through a self-service tool that meets the following requirements. The self-service tool must:

- Be based on an internet website;
- Provide for real-time responses to requests;
- Be updated to be timely and accurate;
- Allow individuals to make requests by:
    - A specific participating provider;

- All participating providers; or
- All providers that are not participating providers;

- Provide that a request may be made by billing code or descriptive term; and
- Meet any other requirements determined appropriate by the Secretary.

The Secretary may require such tool to link multiple billing codes to a single descriptive term if the Secretary determines that the billing codes to be so linked correspond to similar items and services.

At the option of the individual, the information described above must also be available in paper format, over the phone, or through other electronic disclosure, at no cost to the individual, as meets such requirements as the Secretary may specify.

Machine-readable files

The proposal requires that each group health plan make available to the public the following information:

- In-network rate information for each item and service for which benefits are available under the plan, other than a drug, other than a rate that is in effect for a provider that did not submit any claim for the relevant item or service within the one-year period ending 10 business days before the date of publication.
- In-network drug price information for each drug (identified by NDC) for which benefits are available under the plan, including the average amount paid by the plan (net of rebates, discounts, and price concessions) for such drug dispensed or administered during the 90-day period beginning 180 days before the date of publication, broken down by each provider, other than amounts paid to a provider that, during such period, submitted fewer than 20 claims for such drug to such plan.
- Out-of-network price information, including, for each item or service for which benefits are available, the amount billed, and the amount allowed, broken down by provider, for each item or service furnished during the same 90-day period as applicable for prescription drug information, other than items or services for which fewer than 20 claims were submitted during the relevant period for such plan.

This information must be made available for plan years beginning on or after the date that is no later than two years after the date of enactment. The information related to in-network rates and out-of-network price information must be made available every three months thereafter, in machine-readable file format (or successor technology, such as application program interface technology, as determined to be appropriate by the Secretary) as two separate files that meet requirements specified by the Secretary. Information related to prescription drug prices must be made available every month thereafter, in the same format as the other two files.

The requirements specified by the Secretary must ensure that such files are limited to an appropriate size, do not contain information that is unnecessarily duplicative of information

contained in other files made available pursuant to the machine-readable file requirement, are made available in a widely-available format through a publicly-available website that allows for information contained in such files to be compared across plans, and are accessible to individuals at no cost and without the need to establish a user account or provide other credentials. The machine-readable file requirement does not apply to grandfathered plans.

Each plan must also make available to the public instructions written in plain language explaining how individuals may search for this information. The Secretary is required to develop and publish a template that a plan may use in developing these instructions. The proposal requires plans to post, along with rate and payment information made public by such plan, an attestation that such information is complete and accurate.

The proposal also requires the Comptroller General to submit a report to Congress not later than January 1, 2027, containing an analysis of compliance with the requirements described above, an analysis of enforcement by the Departments, and any recommendations for improving enforcement.

Finally, the proposal requires that the Departments take reasonable steps to ensure the accessibility of the information made available under the proposal, including reasonable steps to ensure that such information is provided in plain, easily understandable language and that interpretation, translations, and assistive services are provided to make the information accessible to those with limited English proficiency and those with disabilities.

Effective Date

The proposal is generally effective for plan years that begin on or after the date that is two years after the date of enactment. In addition, the proposal specifies that nothing in the proposal may be construed as affecting the applicability of the TiC Final Rules for any period prior to the effective date.

B. Oversight of Pharmacy Benefits Manager Services

Present Law

The Departments are responsible for regulating group and individual health insurance and group health plans.

Pharmacy benefits managers ("PBMs") are third-party administrators that manage prescription drug benefits for a group health plan or health insurance issuer. PBMs typically process prescription drug claims, maintain prescription drug formularies on behalf of the plan or issuer, contract with pharmacies for reimbursement, and negotiate prices with drug manufacturers.[20] Although plans and issuers are required to report information related to prescription drug benefits to the Departments,[21] there is currently no Federal law requiring PBMs to make similar reports to health insurance plans and issuers in general, or to group health plan sponsors.

Description of Proposal

The proposal prohibits a group health plan or an entity or subsidiary providing pharmacy benefits management services ("PBM services")[22] on behalf of such a plan from entering into a contract with a drug manufacturer, distributor, wholesaler, subcontractor, rebate aggregator, or any associated third party that limits the disclosure of information to plan sponsors in such a manner that prevents the plan, or an entity or subsidiary providing pharmacy benefits management services on behalf of a plan, from making reports related to PBM services, as described below.

Plans or entities providing PBM services on behalf of a plan must submit these reports to plan sponsors[23] at least annually and make the reports available to the plan sponsor in a machine-readable format. The report must include, with respect to the plan for the plan year:

- To the extent feasible, information collected from drug manufacturers by the PBM on the total amount of copayment assistance dollars paid, or copayment cards applied,

[20] For a discussion of PBMs and certain required disclosures in the individual health insurance market context, see Patient Protection and Affordable Care Act; HHS, Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards, Final Rule, 86 Fed. Reg. 24140, May 5, 2021.

[21] See sec. 9825, sec. 725 of ERISA, and sec. 2799A-10 of the PHSA, as added by sec. 204 of division BB of the 2021 CAA; see also 45 C.F.R. sec. 184.50 (PBM reporting provision implementing section 1150A of the Social Security Act related to health insurance offered by qualified health plans, which are typically offered an on Exchange created under section 1311 of the PPACA).

[22] For simplicity, this document generally refers to entities covered by the disclosure requirements in this provision simply as "PBMs".

[23] As defined in section 3(16)(B) of ERISA.

that were funded by the drug manufacturer with respect to the participants and beneficiaries in such plan;

- A list of each drug covered by such plan that was dispensed during the plan year, including, with respect to each drug during the plan year:
    - The brand name, chemical entity, and NDC;
    - The number of participants and beneficiaries for whom the drug was dispensed during the plan year, the total number of prescription claims for the drug (including original prescriptions and refills), and the total number of dosage units of the drug dispensed across the plan year, disaggregated by dispensing channel (such as retail, mail order, or specialty pharmacy);
    - The wholesale acquisition cost, listed as cost per days supply and cost per pill, or in the case of a drug in another form, per dosage unit;
    - The total out-of-pocket spending by participants and beneficiaries on such drug, including spending through copayments, coinsurance, and deductibles;
    - For any drug for which the plan's gross spending exceeded $10,000 during the plan year: (1) a list of all other drugs in the same therapeutic category or class; and (2) the rationale (if applicable) for preferred formulary placement of such drug in that therapeutic category or class;
    - The amount received, or expected to be received, from drug manufacturers in rebates, fees, alternative discounts, or other remuneration for claims incurred for such drug during the plan year;
    - The total net spending, after deducting rebates, price concessions, alternative discounts or other remuneration from drug manufacturers, by the plan on such drug; and
    - The net price per course of treatment or single fill, such as a 30-day supply or 90-day supply, incurred by the plan and its participants and beneficiaries, after manufacturer rebates, fees, and other remuneration for such drug dispensed during the plan year.
- A list of each therapeutic category or class of drugs that were dispensed during the plan year, and, with respect to each such therapeutic category or class of drugs, during the plan year:
    - Total gross spending by the plan, before manufacturer rebates, fees, or other manufacturer remuneration;
    - The number of participants and beneficiaries who were dispensed a drug cover by such plan in that category or class, broken down by each such drug (identified by NDC);

- If applicable, a description of the formulary tiers and utilization management (such as prior authorization or step therapy) employed for drugs in that category or class; and

- The total out-of-pocket spending by participants and beneficiaries, including through copayments, coinsurance, and deductibles;

- Total gross spending on prescription drugs by the plan during the plan year, before rebates and other manufacturer fees or remuneration;
- Total amount received, or expected to be received, by the plan in drug manufacturer rebates, fees, alternative discounts, and all other remuneration received from the manufacturer or any third party, other than the plan sponsor, related to utilization of drug or drug spending under the plan during the plan year;
- The total net spending on prescription drugs by the plan during the plan year; and
- Amounts paid directly or indirectly in rebates, fees, or any other type of remuneration to brokers, consultants, advisors, or any other individual or firm for the referral of the plan's business to the PBM.

PBMs are required to report the information in a manner consistent with the privacy, security, and breach notification regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[24] and follow HIPAA use and disclosure restrictions.[25] In addition, plans may disclose this information only to business associates as defined in HHS regulations.[26]

The Secretary also is required to issue rules defining a limited form of the report described above for use by plan sponsors who are drug manufacturers, drug wholesalers, or other direct participants in the drug supply chain, in order to prevent anti-competitive behavior.

Effective Date

The proposal applies to plan years beginning on or after the date that is three years after the date of enactment.

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[24] Pub. L. No. 104-191, sec. 264(c), August 21, 1996.

[25] The proposal permits PBMs to place reasonable restrictions on the public disclosure of this information, except that the PBM may not restrict disclosure to the Departments, the Comptroller General of the United States, or applicable State agencies. PBMs are also required to submit the first four reports (and other reports as requested) to the Comptroller General. The Secretary is required to specify standards for a standard format for these reports not later than eighteen months after the date of enactment. In addition, The Comptroller General is directed to submit to Congress a report on pharmacy networks and related issues not later than three years after the date of enactment.

[26] See 45 C.F.R. sec. 160.103.

C. Estimated Revenue Effects of the Proposal

1. Promoting group health plan price transparency

The proposal is estimated to have no effect on Federal fiscal year budget receipts for the period 2023-2033.

2. Oversight of pharmacy benefits manager services

An estimate of the effects on Federal fiscal year budget receipts will be provided by the Congressional Budget Office.