Misperceptions about PBM Transparency

Pharmacy Benefit Managers (PBMs) support and practice actionable transparency that enables patients, their physicians, and health plan sponsors to make informed decisions on how best to manage prescription drug costs and empowers policymakers with the information they need to make the right policy decisions to lower drug costs for all Americans. Additionally, PBMs are required to produce certain information for government entities, further ensuring clarity on the value they provide.

PBMs Provide Actionable Transparency

Through contractual arrangements, PBMs provide several actionable transparency measures that reduce drug costs, including the following:

Information for patients:

- Premiums
- Cost sharing for drugs in their health plan
- Out-of-pocket maximum cost
- What drugs are covered and on what formulary tier
- What pharmacies are in the network
- Expected annual out-of-pocket costs for their prescription
- Safety information about potential drug interactions

Information for physicians:

- The plan's utilization management requirements, including for prior authorization and step therapy, and how to meet them
- Real Time Benefit Tools that show the patient's formulary and cost sharing

Information for employers, unions, and other health plan sponsors:

- The PBM-plan sponsor contract provides clear and understandable financial information about rebates, fees, and payments
- PBMs submit to regular audits by the health plan to demonstrate they are living up to their contract
- PBMs detail how much plans will pay for each prescription filled by an enrollee in their plan
- PBMs provide aggregate data on drug utilization by plan enrollees

Drug Pricing Transparency Required by the Federal Government

Several federal departments and agencies require extensive reporting from various health care entities on drug pricing.

- **The Center for Medicare & Medicaid Services (CMS)** requires reporting from multiple entities:
  - Exchange and Medicare Plans must publicly report data on numerous administrative processes like **coverage determinations** and **prior authorization**; **benefits design**; **generic dispensing rate** (by pharmacy type); the aggregate **amount and type of rebates**, **discounts**, or **price concessions** (excluding bona fide service fees) that are attributable to patient utilization, those that are passed on to the plan sponsor; the **total number of prescriptions** that were dispensed; and the **difference between the amount the health plan pays the PBM and the amount that the PBM pays retail and mail order pharmacies**.
    - Part D plans must also submit **Prescription Drug Event (PDE)** records, a summary of Part D claims activities for each drug dispensed. When plans submit PDEs to CMS for payment, they include any **pharmacy dispensing fee**. As part of the bid and reconciliation processes, PBMs (via the plans) must report **estimated pharmacy and manufacturer DIR**, including **rebates** and **other price concessions**. Part D plans and the PBMs that administer them must implement **real-time benefits tools** to give patients and prescribers cost sharing and benefits information at the point of prescribing.

- Beginning December 27, 2022, **the Departments of Treasury**, **Health and Human Services**, and **Labor** will require:
  - PBMs to supply plans with:
    - The **50 most frequently dispensed brand prescription drugs**.
    - The **50 costliest prescription drugs** by total annual spending.
    - The **50 prescription drugs with the greatest increase in expenditures** from the previous year.
    - **Prescription drug rebates**, **fees**, and **payments by drug manufacturers** in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates.
    - The **premium and out-of-pocket cost impact** of prescription drug rebates, fees, and other payments.
  - Plan sponsors, issuers, and Federal Employees Health Benefits (FEHB) carriers generally will be required to submit this information aggregated at the state/market level, rather than separately for each plan.

- The Securities and Exchange Commission requires:
  - Publicly traded health plans and PBMs to report **quarterly and annual financial information** to the SEC.