Comparison of PBM Reporting and Related Policies in the Commercial Market as Reported Out by the House and Senate Committees

	PATIENT Act of 2023 (EC Version) §§107 and 304	Transparency in Coverage Act of 2023 (EW Version) §3	Health Care Price Transparency Act of 2023 (WM Version) §103	PBM Reform Act (HELP Version) §2 and Amendments at Markup	Modernizing and Ensuring PBM Accountability Act (Finance Version)	Pharmacy Benefit Manager Transparency Act (Commerce Version) §4
	Prohibits group health plans or health insurance issuers and PBMs (or subsidiaries) from entering contracts with drug manufacturers, distributors, wholesalers, subcontractors, rebate aggregators, or any associated third party that limits the disclosure of certain information to plan sponsors.	Same as EC Version.	Same as EC Version.	Prohibits group health plans or health insurance issuers and PBMs from entering contracts with drug manufacturers, distributors, wholesalers, subcontractors, rebate aggregators, or any associated third party that limits the disclosure of certain information to plan sponsors, or applicable group purchasing organizations (GPOs) or any subsidiary, parent, affiliate, or subcontractor of a plan or issuer, or PBM of such a plan. Specifies applicable group purchasing organizations are those owned by PBMs—narrowing the definition.	No similar provision.	No similar provision.
Timing of Report	Begins January 1, 2025. Annually thereafter.	Same as EC Version.	Begins 3 years post-enactment. Annually thereafter.	Begins 30 months post-enactment. Annually thereafter.	No similar provision.	No similar provision.
Application of Report	Reports required to plan sponsors of both fully-insured and self-insured products for employers of all size.	Reports required to plan administrators of both fully-insured and self-insured products for employers of all size. Indicated in the "Required Information to Report to Plan Sponsors and Plan Administrators", certain items are reported only with respect to large employer plans or for all private market plans.	Same as EC Version.	Reports required to plan sponsors of both fully-insured and self-insured products for employers of all size. Outlines opt-in requirements for fully-insured health plans. Plan sponsors with fewer than 50 employees are to receive a report with aggregated information.	No similar provision.	No similar provision.
Form of Report	Machine-readable format.	Machine-readable format and other formats as specified by the tri-Secretaries.	Same as EC Version.	Machine-readable format and plain language requirement, and other formats as specified by the tri-Secretaries.	No similar provision.	No similar provision.

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Required Information in Report to Plan Sponsors or Plan Administrators	1. Information collected from drug manufacturers on total copayment assistance dollars paid or copayment cards applied. 2. Reporting based on claims filed. Includes WAC reporting by cost per days' supply, cost per dosage unit. 3. Threshold for reporting is for any drug for which gross spending exceeds $10,000 during the reporting period. 4. For each therapeutic category and class which includes 3 or more drugs: gross spending, utilization, formulary tiers, and total-out of pocket spending. 5. For each therapeutic category or class with 3 or more drugs included on formulary: rebates and other remuneration that has been paid by manufacturers related to utilization under the plan, total net spending; net price per course of treatment or single; total gross spending 6. Total remuneration expected to be received from any other third party related to utilization under the plan. 7. Total net spending on drugs by the plan. 8. Amounts paid directly or indirectly to brokers, consultants, advisors, or others who referred the issuer or PBM. No summary document requirement.	Requirements are shown as a comparison to the EC version for succinctness. 1. No substantive difference. 2. No substantive difference from EC Version, but limited to large employer coverage. 3. No substantive difference from EC Version, but limited to large employer coverage. Total amount of gross spending by the plan required generally. 4. No substantive difference, but limited to large employer coverage. 5. No substantive difference, but limited to large employer coverage. 6. No substantive difference. 7. No substantive difference. 8. No substantive difference. Additional reporting required for drugs dispensed at pharmacies with common ownership or with the PBM, including: 1. Explanation of any benefit design parameters that encourage or require filling prescriptions at such pharmacies. 2. List of drugs dispensed at and charged to such pharmacies and specified amounts (e.g., 30-day and 90-day supply; median amount, middle 50%; lowest cost per dosage, net acquisition cost; ASP, WAC, NADAC if determined by Secretary).	Requirements are shown as a comparison to the EC version for succinctness. 1. Info is required to the extent it is feasible. Info is also required from entities administering copay assistance on behalf of manufacturers. 2. Reporting based on drugs dispensed. Includes WAC reporting by cost per days' supply, cost per dosage unit. 3. No substantive difference. 4. Rather than reporting on drugs in therapeutic category and class which includes 3 or more drugs, reporting is based on whether spending exceeded $10,000. 5. No substantive difference. 6. No substantive difference. 7. No substantive difference. 8. No substantive difference. No summary document requirement.	Requirements are shown as a comparison to the EC version for succinctness. 1. No substantive difference. 2. No substantive difference. 3. For any drug which is in the plan's top-50 for highest gross spending during reporting period: rationales for formulary placement will be selected from a list established by the tri-Secretaries. 4. No substantive difference. 5. Similar but replaces " net price per course of treatment or single fill" with "average net spending". 6. No substantive difference. 7. No substantive difference. 8. No substantive difference. 9. New: Expands language to include "the retention of the entity by the group health plan or health insurance issuer." Requires PBMs to submit a summary report to plan sponsors, including reported information determined useful by the tri-Secretaries, for the purpose of choosing between PBMs.	No similar provision.	No similar provision.

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Intra-Company Prescription Drug Transaction Reporting	No similar provision.	No similar provision.	No similar provision.	Reporting for intra-company drug transactions with pharmacies that are "affiliated with or under common ownership" of the PBM: 1. Explanation of benefit design that encourages prescription fills through mail order, specialty, or retail pharmacies with common ownership with the plan. Reporting must include information any requirements or copayment incentives funded by PBMs. 2. The percentage of prescriptions dispensed by mail order, specialty, or retail pharmacies with common ownership with the plan. 3. Requires reporting based on the drugs dispensed by pharmacies with common ownership during an applicable quarter, including: a. Amount charged per dosage unit, per 30-day supply, or 90-day supply to plan or enrollee. b. Median amount, middle 50 percent, and the lowest amount charged to plans and enrollees. c. Net acquisition cost per dosage unit per typical course of treatment if the drug is subject to a maximum price discount. Other cost information determined by the Secretary.	No similar provision.	No similar provision.
Rulemaking	Requires the tri-Secretaries to issue rules within 6 months of enactment on the standards for reporting.	Same as EC Version.	Requires the tri-Secretaries to issue rules within 18 months of enactment on the standards for reporting.	Requires the tri-Secretaries to issue final rules within two years of enactment on the reporting requirements.	No similar provision.	No similar provision.
Limited Form of Report for Small Employers	No similar provision.	No similar provision.	No similar provision.	Plan sponsors with fewer than 50 employees are to receive a report with aggregated information, but information reported to small employers is slightly narrowed. Requires the report to include the summary "shoppable" report.	No similar provision.	No similar provision.
Opt-In for Fully Insured Plans	No similar provision.	No similar provision.	No similar provision.	Outlines opt-in requirements for fully-insured health plans. Still requires mandatory reporting of the summary report information for purposes of enabling sponsors to choose between PBMs.	No similar provision.	No similar provision.

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Disclosures	Disclosure limited to business associates. Plans and PBMs may place reasonable restrictions on disclosure. Government creates a limited form of report for disclosure to plan sponsors who are in the drug supply chain. Limits plan sponsor disclosure to delineated purposes including for research, in response to a court order, to a contractor/agent, or to a federal agency. Gives the tri-Secretaries latitude to determine what "reasonable restrictions" are that can be put in place by PBMs and issuers.	Same as EC Version.	Same as EC Version.	Same as the EC Version.	No similar provision.	No similar provision.
Written Notice	No similar provision.	No similar provision.	No similar provision.	Plan sponsors must inform employees of the requirement for health insurance issuers or group health plans and PBMS to produce the reporting requirements for the plan sponsors. Such information may be included in an employee handbook or other plan documents.	No similar provision.	No similar provision.
Shoppability Report	No similar provision.	No similar provision.	No similar provision.	Requires PBMs to produce a report for purposes of enabling plan sponsors to shop for PBM services. Gives the tri-Secretaries authority to design the report. In addition to the summary shoppability report for plan sponsors, requires the development of a separate summary document for participants or beneficiaries containing information reported by PBMs and issuers that the Secretaries determine useful for helping to better understand their plan or benefits (aggregate information only).	No similar provision.	No similar provision.

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Enforcement	Failure to disclose penalty of $10,000/day (waivable by Government). Penalties payable by pharmacies so that penalties only required are for fraudulent claims, claims inconsistent with reimbursement terms, or for services were not rendered. False information penalty (not including information from manufacturers) of up to $100,000 for each instance.	Same as EC Version .	Same as EC Version.	Same as the EC Version.	No similar provision.	It "shall be unlawful" to provide false or misleading information to a Federal agency that was required to be reported and it was known that the information would affect analyses. Violations of legislation treated as violation of unfair or deceptive act or practice by the FTC. Any person that violates legislation liable for CMP of not more than $1,000,000. Enforcement may be carried out by State AG if a practice that violates this Act poses a threat or adversely affects the interests of the residents of a State. If a State AG lacks appropriate jurisdiction to bring a civil action under paragraph, another authorized officer of the State may do so instead. Defendant has the burden of persuasion by a preponderance of the evidence.
Spread Pricing and Other Practices	No similar provision.	No similar provision.	No similar provision.	Prohibits spread pricing, excluding penalties paid by pharmacies. Defines penalties paid by pharmacies to include only: (1) fraudulent claims; (2) claims made inconsistent with the terms of the reimbursement contract; or (3) claims for services not rendered. Requires that private health plans "ensure" that spread pricing does not occur and that the drug is covered under the plan.	No similar provision.	Except as provided in cell below, prohibits PBMs (and any affiliate, subsidiary, or agent) from doing any of the following: 1. Charge a health plan or payer a different amount for a prescription drug's ingredient cost or dispensing fee than the PBM reimburses the pharmacy (cannot be retained by PBM). 2. Arbitrarily, unfairly, or deceptively reduce, rescind, or claw back reimbursements to a pharmacist or pharmacy for a prescription drug's ingredient cost or dispensing fee. 3. Arbitrarily, unfairly, or deceptively raise fees or decrease reimbursement to a pharmacy to prevent offsetting reimbursement from the Federal Government.

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Rebate Pass-Through/ Other Remuneration	No similar provision.	No similar provision.	No similar provision.	Requires that 100% of rebates, fees, alternative discounts, and all other remuneration from an issuer, PBM, or TPA related to drug utilization is passed to the group health plan. Excludes bona fide service fees provided such fees are transparent to the health plan. Requires PBMs to make available for audit rebate contracts with drug manufacturers at least once per plan year.	No similar provision.	Requires PBMs (and any affiliate, subsidiary, or agent) to pass 100% of any price concession to a health plan or payer including any rebate, discount, or other price concession.
Disclosure of Broker and Consulting Fees	No similar provision.	No similar provision.	No similar provision.	Requires that covered service providers who offer PBM services or third-party administration services to ERISA-covered group health plans furnish written information about their fees and services to the responsible plan fiduciary.	No similar provision.	No similar provision.
Payment and Cost-Sharing Requirements Using Current-Law PBM Reporting	For "highly rebated drugs" as certified by the HHS Secretary, which is based on current-law reporting as required by the CAA 2021 §204, group health plans and health insurance issuers are prohibited from receiving from drug manufacturers a reduction in price or other remuneration for a highly rebated drug that was not covered in a previous year (or does not have a net price calculated based on the Secretary's aggregation of PBM reporting requirements), unless the reduction in price is reflected at the point of sale to the enrollee. Cost-sharing for any highly rebated drug (see below) shall not be more than, per 30-day supply, the quotient of the annual net price paid by a plan or PBM in the previous calendar year, per 30-day supply of such specific highly rebated drug, divided by 12. Requires the HHS Secretary to certify a 'highly rebated drug' as any drug for which total rebates, reductions in price, and other forms of remuneration in the previous year exceeded 50 percent of total annual spending on such drug in a year.	No similar provision.	No similar provision.	No similar provision.	No similar provision.	No similar provision.

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GAO Reporting	Required reporting by issuers and PBMs to GAO of first 4 reports submitted to the for the purpose of conducting a study and submitting a report to Congress (as described below in d Study).	Nearly the same as the EC Version, except reporting is not required on information determined necessary by the GAO to complete a GAO Study as in the EC Version (as there is not GAO Study requirement).		Reporting by health insurance issuers, group health plans, and PBMs to GAO "upon request" of the first 2 reports above to GAO to study pharmacy networks (as described below in GAO Study).	No similar provision.	No similar provision.
GAO Study	Requires a report within 3 years of enactment on pharmacy networks (including pharmacies under common ownership of plans/PBMs), whether plans have the option of selecting different network pricing arrangements, arrangements that encourage individuals to use pharmacies under common ownership, the reimbursement level for drugs dispensed at pharmacies under common ownership, and the degree to which mail order, specialty, or retail pharmacies that dispense drugs to an enrollee in a group health plan or coverage offered by a health insurance issuer under common ownership provide administrative services receive reimbursement that is greater than the median price charged to the plans not under common ownership.	No similar provision.		Requires a report by January 1, 2029 on pharmacy networks (including pharmacies under common ownership of plans/PBMs), whether plans have the option of selecting different network pricing arrangements, arrangements that encourage individuals to use pharmacies under common ownership, and the reimbursement level for drugs dispensed at pharmacies under common ownership.	No similar provision.	Requires a report within 1 year of enactment that addresses: 1. Role of PBMs in the pharmaceutical supply chain. 2. State of competition among PBMs. 3. Use of rebates and fees. 4. Formulary structure to see if it favors high cost drugs. 5. Average prior authorization approval time. 6. Factors affecting use of step therapy. 7. Extent PBMs charge payors more than such PBM pays pharmacy. Requires GAO to provide recommendations to lower drug costs, improve efficiency in supply chain, and increase competition, and increase transparency.
DOL Study	No similar provision.	No similar provision.	No similar provision.	Requires the Labor Secretary to submit a report to Congress on the impact of a change in policy as to whether (1) a PBM is considered a fiduciary under ERISA, and (2) a PBM is subject to requirements and disclosures under ERISA.	No similar provision.	No similar provision.
Access to Information	No similar provision.	No similar provision.	No similar provision.	Requires health plans and PBMs to provide data on the individual's health claims, provider encounters, and payments, made available for access and exchange through application programming interfaces.	No similar provision.	No similar provision.

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FTC Reporting	No similar provision.	No similar provision.	No similar provision.	No similar provision.	No similar provision.	Requires PBMs to annually report to the FTC the following information: 1. Aggregate amount of the difference in amount paid to PBM by each plan and amount paid to each pharmacy for prescription drugs. 2. Aggregate amount generic effective rate, DIR fee charged or other price concession, payment rescinded or otherwise clawed back. 3. PBM reassigned a drug to a formulary tier with higher cost, copayment, coinsurance, or higher deductible; lower reimbursement; and an explanation. 4. For affiliated pharmacies a report on differences in reimbursement rates or practices, DIR fees or other price concessions, and clawbacks.
Whistleblower Protections	No similar provision.	No similar provision.	No similar provision.	No similar provision.	No similar provision.	Provides several whistleblower protections for covered individuals associated with PBMs, health plans, pharmaceutical manufacturers, pharmacies, or their affiliates, subsidiaries, or agents.

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Step-Therapy Requirements	No similar provision.	No similar provision.	No similar provision.	Requires a group health plan or health insurance issuer to establish an exception to medication step-therapy protocol in specified cases. Request for an exception to the protocol must be granted if either: 1. An otherwise required treatment has been ineffective. 2. Such treatment is expected to be ineffective and delaying effective treatment would lead to irreversible consequences. 3. Such treatment will cause or is likely to cause an adverse reaction to the individual. 4. Such treatment is expected to prevent the individual from performing daily activities or occupational responsibilities. 5. The individual is stable based on the prescription drugs already selected. 6. Other circumstances as determined by EBSA.	No similar provision.	No similar provision.