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Healthcare Transparency Package Coming

House Bill Hits All Healthcare; ASC Provisions Likely to Change (or Drop)

Relevant Companies

Our Take & Next Up

The Ambulatory Surgery Center (ASC) transparency reporting for hospital-owned ASCs is likely to be modified to include (1) all ASCs or (2) hospital-owned reporting could be dropped from the bill entirely. The provision unveiled last week was viewed as a surprise as it singled out a small slice (20%) of the ASC market. See below for all provisions. Other observations: PBM measures are better than provisions in other PBM bills, but we don't rule out passage of de-linking, banning spread and provisions in other 2023-passed Committee bills. The physician-administered "site neutral" drug piece will likely pass (saves $3 B or so).

Healthcare transparency framework was released last week with language forthcoming this week. The House Healthcare Committees — Ways & Means, Education & Labor, and Energy & Commerce — released a healthcare transparency framework for inclusion in a healthcare package this fall, with legislative language formally introduced over the next 2-3 days. We view these measures as largely palatable to both sides of the aisle. The goal would be to glean savings and offset the Medicaid DSH cuts to hospitals slated to take effect ($8 B per year).

Key Points

Ambulatory Surgery Centers (ASC) – We think that the hospital-owned only language will be modified to include all ASCs, or transparency for ASCs dropped entirely.

- **Ambulatory Surgical Center (ASC) Price Transparency Requirements** introduced by GOP only, starting January 1, 2026, requires hospital-owned ASCs to publish cash prices and insurer-negotiated rates for all items and services and requires publication of prices for at least 300 shoppable services or a consumer-friendly price estimator tool.

Hospitals – This is as expected. Parity for physician administered drugs is likely to pass in 2023 (saves $2 B or so).

- **Hospital Price Transparency Requirements** introduced by Pallone (D-NJ) with bipartisan support. Beginning January 1, 2026 hospitals will be required to publicly make available all standard charges for items and services through machine-readable files (MRFs) and payer-specific negotiated charges, including for cash-paying patients.
- **Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus saves about $3 B and is likely to pass in 2023. I**ntroduced by Rogers (R-WA) and Pallone (D-NJ), this section ensures Medicare is paying the same rates for physician-administered drugs in off-campus hospital outpatient departments as in physician offices.
- **Requiring a Separate Identification Number and an Attestation for Each Off-Campus Outpatient Department of a Provider** introduced with bipartisan support, this requires each off-campus outpatient department of a Medicare provider to obtain and include a national provider identifier on billings for claims and services starting January 1, 2026.

Health Plans

- **Promoting Health Coverage Price Transparency** introduced by Pallone (D-NJ) with bipartisan support, starting January 1, 2026, requires group health plans to make personalized pricing information available to enrollees and to post publicly machine-readable files (MRFs) containing in-network negotiated rates, prescription drug prices, and out-of-network allowed amounts.
- **Increasing Plan Fiduciaries' Access to Health Data** introduced with bipartisan support, this ensures health plan fiduciaries are not restricted from received cost or quality of care information about their health plan.

Pharmaceuticals – This is fine and contains no new ideas.

- **Increasing Transparency in Generic Drug Applications (FDA)** introduced with bipartisan support requiring the FDA to disclose new generic drug applicant ingredients, if any, that cause a drug to be quantitatively or qualitatively different from the listed "brand" drug.
- **Information on Prescription Drugs.** This section confirms that existing law banning gag clauses (practices that prevent pharmacists from communicating lower-cost drug options to patients) applies to all private health plans.

PBMs – Less onerous than PBM bills passed this year, but if the below pass the Congress, additional policies are likely in 2023 (Spread ban, De-linking, per Senate Finance bill).

- **Oversight of Pharmacy Benefits Manager Services** introduced with wide bipartisan support. Starting 2 years from enactment, it requires PBMs to semi-annually provide employers with detailed data on prescription drug spending, including the acquisition cost of drugs, total out-of-pocket spending, formulary placement rationale, and aggregate rebate information. It also requires the GAO to submit a report on practices of pharmacy networks of group health plans.
- **Improving Transparency and Preventing the Use of Abusive Spread Pricing and Related Practices in Medicaid** introduced with bipartisan support, starting 18 months after enactment, this prohibits PBMs that contract with Medicaid MCOs from spread pricing. It also requires pharmacies to report actual acquisition costs for drugs.
- **Hidden Fees Disclosure Requirements** introduced with bipartisan support, this requires PBMs and Third-Party Administrators disclose compensation to plan fiduciaries starting January 1, 2025.

Medical Devices/Diagnostic Tests

- **Increasing Price Transparency of Clinical Diagnostic Laboratory Services Under Medicare** extends price transparency requirements to diagnostic labs. Beginning January 1, 2026, labs are required to make publicly available the cash price and the de-identified minimum and maximum insurer-negotiated rates for clinical diagnostic laboratory tests that are included on the list of shoppable services by CMS.
- **Imaging Transparency** introduced by GOP only. Beginning January 1, 2028, this requires providers of certain imaging services to publish cash prices and the de-identified minimum and maximum insurer-negotiated rates.

Reporting Requirements

- **Reports on Healthcare Transparency Tools and Data Requirements** states that starting December 31, 2024 the GAO must report to the committees on existing and new healthcare transparency requirements, compliance, enforcement, and patient utilization.
- **Report on Integration in Medicare** introduced with bipartisan support, this requires MA organizations to report to HHS information on health care providers, PBMs, and pharmacies who they share common ownership with. It also requires MedPAC to report on vertical organization between MA organizations, health care providers, PBMs, and pharmacies.
- **Advisory Committee.** Starting January 1, 2025 an advisory committee must be in place consisting of 9 members to advise on how to improve the accessibility and usability of information collected from Sec. 105 and Sec. 106. The advisory committee sunsets on January 1, 2028.
- **Report on Impact of Medicare Regulations on Provider and Payer Consolidation** requires the Secretary of HHS to submit an annual report on the impact of Medicare regulations and CMMI models on healthcare consolidation no later than December 30, 2026.

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