116TH CONGRESS
2D SESSION

S. 5084

To increase transparency and access to group health plan and health insurance issuer reporting, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 21, 2020

Mr. BRAUN introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To increase transparency and access to group health plan and health insurance issuer reporting, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

(a) PHSA.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following:

"SEC. 2729A. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, and not later than March 1 of each year thereafter, a group health plan or health insurance issuer offering group or individual health insurance coverage (except for a church plan) shall submit to the Secretary, the Secretary of Labor, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year:

''(1) The beginning and end dates of the plan year.

''(2) The number of enrollees.

''(3) Each State in which the plan or coverage is offered.

''(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.

''(5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.

''(6) 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.

''(7) Total spending on health care services by such group health plan or health insurance coverage, broken down by—

''(A) the type of costs, including—

''(i) hospital costs;

''(ii) health care provider and clinical service costs, for primary care and specialty care separately;

''(iii) costs for prescription drugs; and

''(iv) other medical costs, including wellness services; and

''(B) spending on prescription drugs by—

''(i) the health plan or coverage; and

''(ii) the enrollees.

''(8) The average monthly premium—

''(A) paid by employers on behalf of enrollees, as applicable; and

''(B) paid by enrollees.

''(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators

or service providers, with respect to prescription drugs prescribed to enrollees in the plan or coverage, including—

"(A) the amounts so paid for each therapeutic class of drugs; and

"(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

"(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

"(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting through the Assistant Secretary of Planning and Evaluation and in coordination with the Inspector General of the Department of Health and Human Services, shall make available on the internet website of the Department of Health and Human Services a report on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such

plans or coverage, aggregated in such a way as no drug or plan specific information will be made public.

''(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).''.

(b) ERISA.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 716. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, and not later than March 1 of each year thereafter, a group health plan (or health insurance coverage offered in connection with such a plan) shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year:

''(1) The beginning and end dates of the plan year.

''(2) The number of participants and beneficiaries.

''(3) Each State in which the plan or coverage is offered.

''(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.

''(5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.

''(6) 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.

''(7) Total spending on health care services by such group health plan or health insurance coverage, broken down by—

''(A) the type of costs, including—

''(i) hospital costs;

''(ii) health care provider and clinical service costs, for primary care and specialty care separately;

''(iii) costs for prescription drugs; and

"(iv) other medical costs, including wellness services; and

"(B) spending on prescription drugs by—

"(i) the health plan or coverage; and

"(ii) the participants and beneficiaries.

"(8) The average monthly premium—

"(A) paid by employers on behalf of participants and beneficiaries, as applicable; and

"(B) paid by participants and beneficiaries.

"(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan or coverage, including—

"(A) the amounts so paid for each therapeutic class of drugs; and

"(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

''(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

''(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting in coordination with the Inspector General of the Department of Labor, shall make available on the internet website of the Department of Labor a report on prescription drug reimbursements under group health plans (or health insurance coverage offered in connection with such a plan), prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage, aggregated in such a way as no drug or plan specific information will be made public.

''(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).''.

(c) IRC.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 9816. REPORTING ON PHARMACY BENEFITS AND DRUG COSTS.

''(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, and not later than March 1 of each year thereafter, a group health plan shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor the following information with respect to the health plan in the previous plan year:

''(1) The beginning and end dates of the plan year.

''(2) The number of participants and beneficiaries.

''(3) Each State in which the plan is offered.

''(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each such drug.

''(5) The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug.

''(6) 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 in each such plan year.

''(7) Total spending on health care services by such group health plan, broken down by—

''(A) the type of costs, including—

''(i) hospital costs;

''(ii) health care provider and clinical service costs, for primary care and specialty care separately;

''(iii) costs for prescription drugs; and

''(iv) other medical costs, including wellness services; and

''(B) spending on prescription drugs by—

''(i) the health plan; and

''(ii) the participants and beneficiaries.

''(8) The average monthly premium—

''(A) paid by employers on behalf of participants and beneficiaries, as applicable; and

''(B) paid by participants and beneficiaries.

''(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs pre-

scribed to participants or beneficiaries in the plan, including—

"(A) the amounts so paid for each therapeutic class of drugs; and

"(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan from drug manufacturers during the plan year.

"(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

"(b) REPORT.—Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting in coordination with the Inspector General of the Department of the Treasury, shall make available on the internet website of the Department of the Treasury a report on prescription drug reimbursements under group health plans, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans, aggregated in such a way as no drug or plan specific information will be made public.

"(c) PRIVACY PROTECTIONS.—No confidential or trade secret information submitted to the Secretary under

subsection (a) shall be included in the report under subsection (b).''.

(d) CLERICAL AMENDMENTS.—

(1) ERISA.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) is amended by inserting after the item relating to section 714 the following new items:

''Sec. 715. Additional market reforms.
''Sec. 716. Reporting on pharmacy benefits and drug costs.''.

(2) IRC.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''Sec. 9816. Reporting on pharmacy benefits and drug costs.''.

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