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The Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act

Title I – Increasing Price Transparency to Lower Costs.

Sec. 101. Price Transparency Requirements.

- Requires hospitals to make all standard charges for all items and services public through machine-readable files as well as payer-specific negotiated charges, including for cash-paying patients, for at least 300 shoppable services.

Sec. 102. Strengthening Health Insurer Transparency Requirements.

- Requires health insurance companies to make personalized pricing information available to enrollees and post machine-readable files containing in-network negotiated rates, prescription drug prices, and out-of-network allowed amounts.

Sec. 103. Requiring a Separate Identification Number and an Attestation for Each Off-Campus Outpatient Department of a Provider.

- Introduced as H.R. 3237 by Representatives Joyce (R-PA-13) and Sarbanes (D-MD-3), this section requires each off-campus outpatient department of a provider to obtain and include a national provider identifier on billings for claims for services. Additionally, this section requires such off-campus outpatient departments to submit attestations of compliance with the national provider identifier requirements to the Secretary of Health and Human Services (HHS).

Sec. 104. Mandatory Reporting with Respect to Certain Health-Related Ownership Information.

- Introduced as H.R. 3262 by Representatives Schakowsky (D-IL-9) and Bilirakis (R-FL-12), this section requires hospitals, freestanding emergency centers, ambulatory surgical centers, physician practices with more than 25 physicians, physician practices owned by hospitals, insurance companies, and other entities, to report to the Department of Health and Human Services (HHS) ownership information including changes in ownership. HHS would be required to use this data to issue annual reports on trends in health care consolidation.

Sec. 105. Increasing Price Transparency of Clinical Diagnostic Laboratory Tests Under the Medicare Program.

- Introduced as H.R. 3248 by Representatives Miller-Meeks (R-IA-1) and DeGette (D-CO-1), this section extends certain price transparency requirements to diagnostic labs. Specifically, this section requires labs to make publicly available the discounted cash price, the de-identified minimum rate, and the de-identified maximum rate for clinical diagnostic laboratory tests offered by the lab that are included on the list of shoppable services specified by the Centers for Medicare and Medicaid Services (CMS).

Sec. 106. Promoting Transparency of Common Ownership Interests Under Parts C and D of the Medicare Program.

- Introduced as H.R. 3282 by Representatives Harshbarger (R-TN-1) and Schrier (D-WA-8), this section increases transparency into the effects of vertical integration in health care by requiring Medicare Advantage Organizations and Part D plan sponsors to report data with respect to how these companies interact with health care providers that they share common ownership with – including physician groups, pharmacy benefit managers (PBMs), and pharmacies – compared to those that they do not.

Sec. 107. Oversight of Pharmacy Benefits Manager Services.

- Introduced as H.R. 2679 by Representatives Kuster (D-NH-2), Carter (R-GA-1), Eshoo (D-CA-16), and Guthrie (R-KY-2), this section requires PBMs to 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. Additionally, the Comptroller General of the United States would be required to submit a report on the practices of pharmacy networks of group health plans, including networks that have pharmacies that are under common ownership with group health plans.

Title II – Supporting Patients, Health Care Workers, Community Health Centers, and Hospitals

Sec. 201 Extension for Community Health Centers, the National Health Service Corps, and Teaching Health Centers that Operate GME Programs.

- Introduced as H.R. 2559 by Representatives Joyce (R-PA-13), Blunt Rochester (D-DE-At-Large), Stefanik (R-NY-21), and Fletcher (D-TX-7), this section would extend the Community Health Center Fund through calendar year 2025 at $4.2 billion per year and National Health Service Corps through calendar year 2025 at $350 million per year.
- This section would also extend the Teaching Health Center Graduate Medical Education Program for FY24-29, beginning at $175 million in FY24 and increasing to $275 million in 2029. This section also allows HRSA to utilize carryover funds for the THCGME program for FY24 and FY25.

Sec. 202. Special Diabetes Programs.

- Introduced as H.R. 2550 by Representatives DeGette (D-CO-1) and Bilirakis (R-FL-12), this section would extend the Special Diabetes Program through calendar year 2025 at $170 million a year.
- Introduced as H.R. 2547 by Representatives Cole (R-OK-4) and Ruiz (D-CA-25), this section would extend the Special Diabetes for Indians Program through calendar year 2025 at $170 million a year.

Sec. 203. Delaying Certain Disproportionate Share Hospital Payment Reductions under the Medicaid Program.

- Introduced as H.R. 2665 by Representatives Clarke (D-NY-9), Crenshaw (R-TX-2), DeGette (D-CO-1), and Burgess (R-TX-26), this section would eliminate the Medicaid Disproportionate Share Hospital (DSH) cuts for FY24-25.
- The cuts equate to $8b per year in Medicaid funding that is otherwise meant to support high-need hospitals that provide care for high rates of Medicaid and uninsured patients.

Sec. 204. Medicaid Improvement Fund.

- Would eliminate $7b in funds in the Medicaid Improvement Fund.

Title III – Reducing Health Care Costs

Sec. 301 – Increasing Transparency in Generic Drug Application.

- Introduced as H.R. 3839 by Representatives Dunn (R-FL-02) and Kuster (D-NH-02), requires FDA to disclose to new generic drug applicants what ingredients, if any, cause a drug to be quantitatively or qualitatively different from the listed "brand" drug for purposes of establishing sameness in formulation.
- For generic drug applications that include quantitative differences in an ingredient, FDA would be required to provide guidance to help establish sameness.

Sec. 302. Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus.

- This section ensures that Medicare beneficiaries and the Medicare program are paying the same rates for physician-administered drugs in off-campus hospital outpatient departments as beneficiaries and Medicare do in physician offices.

Sec. 303. Improving Transparency and Preventing the Use of Abusive Spread Pricing and Related Practices in Medicaid.

- Introduced as H.R. 1613 by Representatives Carter (R-GA-1), Gonzalez (D-TX-34), Stefanik (R-NY-21), Ross (D-NC-2), Allen (R-GA-12), and Auchincloss (D-MA-4), this section would ban spread pricing in Medicaid and ensure the accuracy of the National Average Drug Acquisition Cost (NADAC) survey in Medicaid.
- Specifically, this section would prohibit pharmacy benefit managers (PBM) that contract with Medicaid managed care organizations (MCOs) from spread pricing.
- In lieu of spread pricing, the language would clarify that States should reimburse PBMs contracting with MCOs for an administrative fee for managing the pharmacy benefit for Medicaid beneficiaries.
- Additionally, this section supports NADAC pricing in Medicaid. Many states use the NADAC price survey to determine actual acquisition costs, with accuracy of the survey contingent on pharmacies filling out the data requested by the survey.
- The policy would require pharmacies to complete the survey and report actual acquisition costs for drugs.

Sec. 304. Requirements with Respect to Cost-Sharing for Highly-Rebated Drugs.

- Introduced as H.R. 3285 by Representative Griffith (R-VA-9), this section would ensure that no patient pays more than the price their insurance company or PBM is negotiating for the drug.
- First, it would require the Secretary to annually certify any drug as a “highly-rebated drug” if aggregate rebates and discounts in the commercial market for such drug exceed 50 percent of aggregate spending in the commercial market for such drug.
- Insurance companies would then be banned from using cost-sharing structures that would lead to a patient paying more out-of-pocket for highly-rebated drugs than the insurance company or PBM is paying the manufacturer after all post-sale rebates and other discounts are accounted for.