The Alliance
Self-Funding Smart®

March 2, 2023

Health Policy Insights

When health policy issues arise – and affect self-funded employers – we will share insights into each issue to better educate employers. These emails will be sent occasionally throughout the year, but primarily during peak "legislative season."

Learn More

At the State Level

Proposals were Introduced Impacting Drug Coupons and Discount Programs

Legislation sought primarily by pharmaceutical companies would require pharmacy benefit managers (PBMs) to apply amounts paid by third parties for brand name prescriptions to any calculation of enrollees' cost-sharing responsibilities. That means the value of any financial assistance offered by drug companies via coupons or other programs would need to be counted toward the satisfaction of deductibles and maximum out-of-pockets (MOOPs), undermining health plan cost-sharing requirements and effectively ending "copay accumulator" pharmacy benefit designs.

Senator André Jacque and Representative Paul Tittl, both Republicans, are introducing companion bills in both houses of the legislature and Democrat Tony Evers has included the proposal in his budget bill. The proposal has attracted strong bipartisan support because numerous patient advocacy organizations (American Cancer Society, the American Diabetes Association, the American Kidney Fund, and others) have gotten behind the legislation. That said, there is also strong opposition from lawmakers that recognize the bill as an attempt by pharmaceutical companies to continue secret pricing schemes that inflate prices for commercial payers.

Copay accumulator plan designs, which are offered by many PBMs as a means to manage drug costs, work by counting only the amounts employees and dependents actually spend out of their pocket toward the calculation of deductibles and MOOPs. That way, eligible employees or dependents can use drug coupons etc. to lower the cost of their medications, but they must satisfy their deductibles and out of pockets with their own money. More importantly, they do not meet their out-of-pocket maximums in just one or two fills.

The Alliance has concerns about the proposals because they would remove the incentive for drugmakers to price name brand medications lower, or to negotiate lower prices with PBMs. In fact, the proposed legislation would incentivize drug makers to price name brand medications higher to maximize the value of their coupon/assistance programs which they commonly advertise. In addition, these programs encourage enrollees to remain on high-priced medications even when they would be eligible for lower-cost alternatives.

At the Federal Level

And Speaking of PBMs…

There is broad bipartisan support for PBM reform and increased transparency at both the state and federal levels. Since an anticipated state bill has not yet been released for input, we'll focus on federal efforts for now.

The Senate Committee on Commerce, Science and Transportation recently held a hearing on the **Pharmacy Benefit Manager Transparency Act of 2023**, bipartisan legislation that would increase federal oversight of PBMs.

The bill would make it illegal for PBMs to engage in "spread pricing," which commonly refers to PBMs' practice of charging plans and employers more for a prescription drug than what they reimburse the pharmacy, and then pocketing the "spread" as profit. The bill also would encourage full and complete disclosure of prices, fees, markups, rebates and discounts to plan sponsors, plus require PBMs to file annual reports to the Federal Trade Commision (FTC).

The legislation was drafted in large part to address concerns from pharmacies, without input from national employer organizations. The ERISA Industry Committee (ERIC) has **outlined several concerns** about the legislation and ways it can be improved. We will keep our readers posted on this issue as the bill moves forward (if it moves forward).

No Surprises Act

Numerous lawsuits have been filed by provider organizations challenging federal rules governing the No Surprises Act and their prioritization of the "Qualified Payment Amount," or QPA, in settling payment disputes. In the lawsuits, providers argue that QPAs based on median in-network rates are deflationary, that they are not calculated correctly by regulation, and that the administration is illegally placing an emphasis on the QPA in the regulations. These lawsuits continue to muck up the roll-out of the No Surprises Act, which has already seen an overwhelming and unexpected number of dispute resolutions filed by providers in hopes of securing higher payments from plans.

For the second time, a Texas court has issued a ruling in favor of providers. The first ruling, issued in February of 2022, forced the Department of Health and Human Services (HHS) to rewrite its initial regulations and direct arbiters settling disputes to weigh factors other than the Qualified Payment Amount (QPA) when settling payment disputes. After HHS issued new rules,

the same plaintiffs filed a similar case under the same judge, to get a second ruling issued this month that says the new regulation "places its thumb on the scale for the QPA" and is still illegal.

HHS will likely respond to the latest ruling on its No Surprises Act webpage which can be found here: **https://www.cms.gov/nosurprises**

Contraceptive Coverage Regulations Issued

Federal agencies have issued proposed regulations that will impact employers that are seeking an exemption to the ACA's contraceptive coverage requirement based on moral or religious objections. The regulations do not impact employers that do not have a religious or moral objection to covering contraceptives. Employers have until April 3, 2023 to submit comments on the legislation. More information can be found **here**.

Health Policy Issues We Are Following

State Issues			
Bill or Issue	**The Alliance Position**	**Summary and Implications for Employers**	**Status**
LRB 1933	We have concerns	Pharma-sponsored legislation that would require self-funded municipal plans and PBMs to count the value of drug coupons offered by drug manufacturers toward deductibles and maximum out-of-pockets, ensuring that anyone using drug coupons will satisfy cost-sharing requirements faster. Since this would apply to PBMs, it is uncertain as to whether the bill would be preempted by ERISA for non-municipal self-funded plans.	Not yet introduced
SB 63 Assignment of Dental Benefits	Still analyzing this bill	Would impact self-funded government plans but not others. Allows an individual insured under a health benefit plan that includes dental coverage to assign reimbursement for dental and related services directly to a dental provider. The plan would then have to directly pay the provider the amount of any claim under the same criteria and payment schedule under which it would have reimbursed the insured.	Referred to Assembly Committee on Insurance and Small Business
AB 43/SB 70 State Budget Bills	We have concerns	The governor's budget includes several policy items that may be of interest to employers, including the inclusion of LRB 1933 as described above. Many of these items are likely to be removed, however, and we will communicate issues of concern as the bill moves toward final passage around June 2023.	Referred to the Budget-Writing Joint Committee on Finance
Federal Issues			
S127 Pharmacy Benefit Manager	We have concerns	Would prohibit "spread pricing" by PBMs and encourage full and complete disclosure of prices, fees, markups, rebates and discounts to plan sponsors, plus require PBMs to file annual reports to the FTC. Committee summary. National employer groups are working on amendments.	Referred to the Senate Committee on Commerce, Science, and

Transparency Act of 2023			Transportation, Hearing held February 16, 2023
No Surprises Act Lawsuits	N/A	There are several lawsuits that challenge the No Surprises Act rules issued by HHS/Labor. Many of the lawsuits are challenging the rule's direction that require arbiters to consider the "Qualified Payment Amount" (QPA or median in network amount) as the dominant factor when settling payment disputes. Since the No Surprises Act took effect on 1/1/22, the lawsuits create uncertainty for health plans. As of today, arbiters are not required to rely on the QPA as the dominant factor, which is likely to lead to more disputes and higher settlement amounts in the interim.	A recent ruling in favor of challengers found that HHS may not place any emphasis on the QPA in regulations. HHS has not yet responded.

** The information provided in this newsletter is for general informational purposes only and does not, and is not intended to, constitute legal advice.*

How Are We Doing?

Answer one question to let us know! How likely is it that you would recommend The Alliance to a friend or colleague?

Highly Unlikely Highly Likely

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