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EMPLOYEE BENEFITS

Health Care Cost Transparency Reporting for Group Health Plans

November 2021

Interim Final Rules addressing medical and prescription drug pricing transparency, as required under the No Surprises Act (part of the 2021 Consolidated Appropriations Act), were jointly issued by the Treasury and the Labor and Health and Human Services Department on November 17, 2021. The interim final rules were published in The Federal Register on November 23, 2021 and are generally effective December 27, 2021. However, the joint rules delay reporting requirements for health plans applicable to 2020 and 2021 calendar years for an additional year until December 27, 2022. For reference, please review our prior article.

The rules also clarify specific details on required reporting elements for group health plans and health insurance issuers offering individual or group health coverage and carriers providing coverage to the Federal Employee Health Benefits (FEHB) program. Under the transparency rules, plans subject to the rules must report cost information for specific categories of health care expenditures on an annual basis. Health reimbursement arrangements and other account-based group health plans, short-term limited-duration insurance and excepted benefits are excluded from the reporting requirements.

Reporting in General

At this time, there are no specific details on how the reporting is to be submitted. The regulations state: "The report must be submitted in the form and manner prescribed by the Secretary, jointly with the Secretary of the Treasury and the Secretary of Health and Human Services." Further guidance is anticipated.

The interim final rules clarify that if the plan is fully insured and the plan and issuer agree in writing that the issuer will comply with the reporting requirements, the issuer, and not the plan, is responsible for any reporting failures. On the other hand, while the sponsor of a self-insured plan may contract with a third party (including carriers, TPAs, pharmacy benefit managers or other third parties) to perform the reporting requirements, the plan is responsible for any reporting violation by the third party.

The reporting rules require plans to provide general information on plan coverage, including plan year beginning and ending dates, the number of participants and beneficiaries or enrollees, and each state in which the plan or coverage is offered. Other than these specific characteristics, plans and issuers or other entities reporting on their behalf (issuers, TPAs or other service providers) should submit most of the required information on an aggregate basis by state and market segment, rather than at the plan level.

Multiple Employer Welfare Association Plans (MEWAs) must reflect the state where the employer (if the plan is sponsored at the individual employer level) or the MEWA has its principal place of business or is incorporated (if the MEWA has no principal place of business).

Prescription Drug Cost Reporting

The rule clarifies that drugs of the same name with different dosages are to be aggregated to prevent duplication in listing the same drug multiple times. Reporting categories include:

1. The total number of paid claims for the 50 most frequently dispensed brand prescription drugs.
2. The amount spent by the health plan for the 50 most costly prescription drugs by total annual spending and the annual cost for each such drug.
3. The 50 prescription drugs with the greatest increase in cost over the previous calendar year. The Interim Rule clarifies that the increase is to be measured in terms of total dollars spent by the plan and by cost-sharing paid by beneficiaries, rather than a percentage increase. Only drugs that were approved for marketing or issued an Emergency Use Authorization by the FDA during the entire reference year and the year that precedes the reference year are to be included.
4. Prescription drug utilization and spending, including:
    - Total annual spending by the plan or coverage;
    - Total annual spending by the participants and beneficiaries, as applicable, enrolled in the plan or coverage, as applicable;
    - The number of participants and beneficiaries, as applicable, with a paid prescription drug claim;
    - Total dosage units dispensed; and
    - The number of paid claims, broken down by drugs covered by the pharmacy benefit and those that are covered under the plan's hospital or medical benefit.

5. Prescription drug rebates, fees and other remuneration, including:
    - Total prescription drug rebates, fees and other remuneration, and the difference between total amounts that the plan or issuer pays the entity providing pharmacy benefit management services to the plan or issuer and total amounts that such entity pays to pharmacies.
    - Prescription drug rebates, fees and other remuneration, excluding bona fide service fees, broken down by the amounts passed through to the plan or issuer, the amounts passed through to participants and beneficiaries, as applicable, and the amounts retained by the entity providing pharmacy benefit management services to the plan or issuer; and the data elements [identified in #4 above]:
        - For each therapeutic class, and
        - For each of the 25 drugs receiving the greatest rebates during the plan year.
6. The method used to allocate prescription drug rebates, fees and other remuneration, if applicable.
7. The impact of prescription drug rebates, fees and other remuneration on premium and cost-sharing amounts.

Medical Cost Reporting

Plans must report:

1. Total annual spending by the plan and by participants and beneficiaries (cost-sharing), broken down by cost type, including:
   - » Hospital costs.
   - » Health care provider and clinical service costs – by primary care and specialty, separately.
   - » Costs for prescription drugs, separately for drugs covered by the plan's or issuer's pharmacy benefit and drugs covered by the plan's or issuer's hospital or medical benefit.
   - » Other medical costs, including wellness services.
2. Average monthly premiums paid by employers, employees and beneficiaries and total annual premium amount and the total number of life-years.

The regulations call for public comments during a period that expires 60 days following publication in The Federal Register (i.e., comments must be received by January 22, 2022). Interested parties may enter comments for consideration during this review period.

Summary

Although the specific deadline for 2020 and 2021 reporting has been delayed, group health plan sponsors will likely want to initiate discussions with their health plan insurers and third-party administrators early to help ensure their written agreements with these service providers address their responsibility for compliance with these cost reporting requirements. Plan sponsors should consult their employee benefits attorneys for specific advice on any needed contract changes.

How Brown & Brown Can Help

Connect with our Brown & Brown Regulatory and Legislative Strategy Group to learn more about how we can help find solutions to fit your unique needs.

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