SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

TO: All Group Health Plans

FROM: Slevin & Hart, P.C.

DATE: January 5, 2022

RE: Interim Final Rule on Health Care Cost Reporting Requirements under the No Surprises Act

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This follows our memorandum dated March 3, 2021 regarding the No Surprises Act, which was enacted in December 2020 as part of the Consolidated Appropriations Act of 2021 ("Act"). As required by the Act, the Departments of the Treasury, Labor, and Health and Human Services (the "Departments") jointly issued an Interim Final Rule ("Rule") on November 17, 2021 that implements the Act's requirements for health plans to annually submit data regarding prescription drug and health care spending to the Departments ("Data"). These reporting requirements apply to both grandfathered and non-grandfathered plans but do not apply to retiree-only plans and plans that provide only "excepted benefits" under ERISA.

1. Executive Summary – Action Items

The Departments are required to issue biennial public reports on prescription drug pricing trends and the impact of prescription drug costs on medical costs. To help with this analysis, plans are required to report to the Departments information about the costliest and most utilized prescription drugs, and prescription drug rebates, fees, and other amounts paid by drug manufacturers to the plan or issuer, broken down by therapeutic drug class and those drugs generating the highest rebate revenue. Plans are also required to report on the impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs. The reporting obligations are based on the calendar year, not the plan year, making the reporting deadline the same for all plans. Given the delayed enforcement by the Departments, the first deadline for plans to report this Data for the 2020 and 2021 calendar years is December 27, 2022.

Plans have the obligation to file the Data, but the Rule permits plans to contract with their vendors (e.g., third-party administrators, PPO network administrators, prescription benefit managers and insurance carriers) to report the Data on their behalf. Vendors that report on behalf of plans can aggregate most of the Data for all the plans they administer. However, for each plan on which they report, the vendor will need to separately identify for each plan included in the report the following information: the Plan Year, the number of participants, beneficiaries and enrollees covered on the last day of the calendar year being reported, and the states in which the

plan offers coverage. Finally, plans can rely on multiple vendors to report the Data. The Rule does not require that the Data be contained in one report for any given plan.

Unless the cost is prohibitive to do so, we assume that plans will want their vendors to submit the Data on their behalf. In addition, because of concerns that prescription benefit managers and PPO network administrators may have with providing certain Data directly to the plan (in particular reporting rebates, fees and other amounts paid by prescription drug manufacturers), it is anticipated that these vendors may want to file these reports on the plan's behalf. Given the December 27, 2022 delayed enforcement deadline, we recommend that plans begin discussions with their vendors and consultants regarding the necessary steps to achieve compliance, including the following:

- The plan will need to determine which vendor or vendors maintain the Data required to be reported, confirm that the vendor or vendors will take on responsibility to file the reports, and evaluate the reasonableness of any additional fees the vendor will charge for doing so.

- If vendor(s) agree to file on behalf of the plan, plans should amend the service agreements with their providers to reflect this reporting responsibility. Plans also should consider indemnification clauses addressing liability for Data reporting errors, especially for self-insured plans, which retain responsibility for timely and accurate reporting even if they contract with a vendor to handle the reporting.

In the event a plan instead chooses to submit the Data itself, the plan may need to enter into contract amendments with vendors to facilitate the release of the necessary information. We will work with the plan on the reporting requirement as necessary in that case.

2. Summary of Requirements

Data must be reported each year for the prior calendar year and not the prior plan year. The Act requires plans to submit Data to the Departments by December 27, 2021 for the 2020 calendar year and then annually thereafter by June 1 of each year subsequent year (i.e., June 1, 2022 for the 2021 calendar year, etc.). However, the Departments have announced that they will temporarily delay enforcement for the 2020 reporting due December 27, 2021 and the 2021 reporting due June 1, 2022 and will not initiate enforcement as long as the plan submits the required Data for the 2020 and 2021 calendar years by December 27, 2022.

a. Data to be Reported

The Data required to be provided include:

(1) Plan identifying information (which likely includes the Plan name, EIN);
(2) The beginning and end dates of the plan year ending on or before the last day of the year being reported;
(3) The number of participants and beneficiaries covered on the last day of the calendar year for which the data is reported;
(4) Each state in which the plan offers coverage;

(5) Enrollment and premium information, including average monthly premiums paid by employees and employers;
(6) Total health care spending, broken down by: (i) hospital costs; (ii) health care provider and clinical service costs, reported separately for primary care and specialty care; (iii) prescription drug costs (see below for further discussion) and (iv) other medical costs, including wellness services;
(7) The 50 most frequently dispensed brand prescription drugs;
(8) The 50 costliest prescription drugs by total annual spending;
(9) The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;
(10) Prescription drug rebates, fees, and other amounts paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs;
(11) Prescription drug rebates, fees, and other amounts paid by drug manufacturers to the plan for the 25 drugs that yielded the highest dollar amount of rebates; and
(12) The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs.

Vendors that provide services to more than one group health plan are permitted to provide the Data in items (5) – (12) in the aggregate for all group health plans they administer, provided that the report is broken down by the state where either the insurance contracts are issued and/or where the plans themselves are located, and by market segment. Market segments for fully-insured coverage are identified as individual, small groups and large groups. Market segments for self-insured coverage are identified as either small employer or large employer; the Rule does not define what is a "small employer" and what is a "large employer". The Rule also does not include a separate market segment definition for multiemployer plans. However, the preamble to the Rule indicates that more detailed instructions will be provided through the portal used for filing the Data. Regardless of how the Data is reported, items (1) to (4) must be reported for each plan separately even if filed by a vendor as part of an "aggregate" report.

b. Reporting of Prescription Drugs under Medical/Hospital Benefit

The Departments acknowledge that some prescription drugs are provided through the hospital or medical benefit and not through a PBM. and that integrating the two classes of drug coverage for purposes of reporting may pose administrative difficulties for plans and vendors. In light of this, prescription drugs covered under the hospital and medical benefit should be reported as a subset of the plan's total annual health spending only, under item (6) above. Prescription drugs covered under the hospital and medical benefit do not have to be included in items (7) – (12). Therefore, if different vendors administer a plan's medical benefit and prescription drug benefit, the vendors can each report the Data separately. The Preamble states that the Departments intend to further review and analyze the merits of this approach as Data is received and may issue additional guidance in the future.

c. Allocation of Responsibility for Reporting – Fully Insured Plans v. Self-Insured Plans

The Rule allows fully-insured plans to comply with their reporting obligations by entering into a written agreement with the health insurance issuer that transfers the responsibility to report

the Data to the issuer. The Rule clarifies that if such an agreement is entered into and the issuer fails to properly report the Data, the issuer, and not the plan, will be in violation of the reporting requirement.

For self-insured plans, however, the Rule makes clear that even if the plan enters into a contract to have its vendors file the Data on behalf of the plan, the plan is still responsible for any untimely or inaccurate reporting. Therefore, assuming self-insured plans choose to have the vendors file the report, plans will likely want to seek indemnification from the vendors for any losses that arise from a vendor's failure to satisfy the reporting obligations of the Rule.

We are available to assist with these tasks as needed, and we will continue to keep you updated as further guidance is issued. In the meantime, please contact us with any questions.

cc: Co-Counsel

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