HEALTH LAW ALERT
November 23, 2021

Insurers, Plans Required to Report Health Care Spending

Must Provide Data on Overall Costs, Prescriptions, and Premiums

Today, the Departments of Health and Human Services, Labor, and Treasury (the Agencies) formally[1] published interim final rules adopting requirements for group health plans and health insurance issuers (**Health Plans**) to report to the Agencies information about annual costs of health care spending, prescription drugs, and premiums (the **Interim Final Rules**).[2] Although the Rules directly apply only to Health Plans, they are likely to affect third-party administrators (**TPAs**) and pharmacy benefit managers (**PBMs**) that collect and maintain data for many Health Plans. The Rules implement requirements of the Consolidated Appropriations Act, 2021 (**CAA**).

Under the Rules, each Health Plan (including each insured and self-funded employer Plan) will be required to report (or have a third party report on its behalf) (i) information sufficient to identify the Plan; (ii) the dates on which the Plan year begins and ends; (iii) the number of Members enrolled in the Plan; and (iv) the State (or States) in which the Plan (or insurance coverage) is offered. The cost data that Health Plans must report may be aggregated, however, such that amounts spent for health care furnished to Members of a specific insured Plan (for example) may be aggregated with amounts for health care furnished to Members of other insured Plans in the same "market segment" (*e.g.*, small group) and State.

The Interim Final Rules are published at 86 *Federal Register* 66662 (click here). Click here for my compilation of Selected Federal Health Insurance Provisions incorporating the Interim Final Rules into previously-published rules (*see* the last two lines under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com).

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[1] The Department informally published the Rules and released them to the public on May 16 when they were filed with the Office of the Federal Register.

[2] The Interim Final Rules are codified at 26 C.F.R. § 54.9825-3T - § 54.9825-6T (Department of the Treasury), 29 C.F.R. § 2590.725-1 - 2590.725-4 (Department of Labor) and 45 C.F.R. Part 149, Subpart H (Department of Health and Human Services).

Deferred Enforcement

Although the CAA and the Interim Final Rules require that reports for the 2020 calendar year be filed by December 27, 2021 (next month), the Agencies have elected to defer enforcement, so that reports for both the 2020 and 2021 calendar years will be due by December 27, **2022** (thirteen months from now). This enforcement discretion is to provide time for (a) the Agencies to develop technical guidance that will establish the manner in which the data must be reported and (b) Health Plans to make preparations for gathering and reporting the data in accordance with the Interim Final Rules and the Agencies' technical guidance. Subsequent reports for each calendar year's spending will be due by June 1 of the following year.

Reporting Costs for Health Care Services

In addition to the Plan-specific information described above, Health Plans will be required to report four categories of total annual spending on health care services aggregated by "market segment" and State. The categories of spending are (i) hospital costs; (ii) health care provider and clinical service costs (distinguishing primary care and specialty care); (iii) prescription drug costs (distinguishing drugs covered by hospital/medical benefits from those covered by prescription drug benefits); and (iv) other medical costs, including wellness services. "Market segments" include:

- Fully-insured small groups;
- Fully-insured large groups;
- Small self-funded plans;
- Large self-funded plans;
- Individual insurance coverage;
- Student insurance coverage; and
- Coverage under the Federal Employees Health Benefit Plan.

Reporting Prescription Drug Coverage

The reporting requirements include detailed information about prescription drug coverage, as well as information about total drug rebates, fees, and other remuneration. Health Plans will be required to provide data for each calendar year with respect to (i) the 50 most-frequently prescribed name-brand prescription drugs; (ii) the 50 most-costly prescription drugs; (iii) the 50 prescription drugs with the greatest increase in expenditures over the previous year; and (iv) the 25 prescription drugs for which it received the largest amount of manufacturer rebates and similar remuneration. These figures, like other cost data, may be aggregated by market segment and State.

Reporting Premium Information

The Interim Final Rules will require Health Plans to report the share of average monthly premium (or "premium equivalent" for self-funded plans) employers (and other plan sponsors) pay for coverage and the share of average premium that Members must pay themselves. Premium data may be aggregated in the same manner as other cost data. The Agencies acknowledge, however, that health insurers and TPAs (who are likely to report aggregated data on behalf of the employer group health plans to which they provide services) generally do not have data about the amount of premium that the employer pays versus the amount the Member pays and that "some employers may not want to disclose this information." Nevertheless, the Agencies require that this information be included in reports under the Interim Final Rules.

Aggregation of Data

The Agencies argue that aggregated cost data will be more useful and will minimize privacy concerns that would arise if smaller plans were required to separately report such information. Under the Interim Final Rules, health insurers must report cost data for coverage they provide in the small and large group (as well as individual) markets. This will provide cost information applicable to insured group health plans. The Agencies anticipate (but do not require) that health insurers will include in their reports other information required of their insured Accounts (*e.g.*, specific information about each insured group health plan (see second paragraph of this Alert, above) and premium data); the Agencies also anticipate that TPAs and PBMs will report information under the Interim Final Rules on behalf of most self-funded group health plans. Thus, the Rules permit a health insurer, TPA, or PBM (a "Reporting Entity") to aggregate cost data for the group health plans to which it provides services (subject to the overall requirements to report data by market segment and State).

One aspect of the Interim Final Rules likely to create controversy is how reports will be aggregated when more than one Reporting Entity (*e.g.*, a TPA and a PBM) is involved. The Interim Final Rules require that data "must not be aggregated at a less granular level than the aggregation level used by the reporting entity that submits the data on total annual spending on health care services." Generally, the entity that submits data on total annual spending will be the TPA (rather than the PBM). Assume, for example, that a PBM provides services to 100 group health plans and those group health plans work with three different TPAs. TPA 1 services 20 of these group health plans; TPA 2 services 30 of these group health plans; and TPA 3 services the remaining 50 group health plans. This provision requires the PBM to aggregate data for TPA 1's 20 group health plans separately from data for TPA 2's 30 group health plans, which must be aggregated separately from TPA 3's 50 group health plans. The Agencies may have difficulty implementing this aspect of the Interim Final Rules, since only Health Plans are required to comply with the Interim Final Rules—not PBMs or TPAs.

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For more information, please contact Tom Bixby at (608) 661-4310 or TBixby@tbixbylaw.com

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