July 23, 2021

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue NW, Room N-5653
Washington, DC 20210

Via Electronic Submission

RE: Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs

Priority Health is an award-winning, Michigan-based, non-profit health plan nationally recognized for improving the health and lives of the nearly million members we serve. As the second-largest health plan in Michigan, and the fourth-largest provider-sponsored health plan in the nation, we are working hard to change the way care is delivered, focusing on affordability, engaging people in their health, and offering innovative products.

We continue to lead the industry in engaging members in their health, delivering effective health and disease management programs while also working with physicians to improve health care outcomes. The State of Michigan has twice named the Priority Health HMO the benchmark plan for all individual and small group plans to model.

Priority Health offers a broad portfolio of health benefit options for employer groups and individuals, including Medicare and Medicaid plans. We follow a mission that places the health of our members first. Our network of health care providers features 97 percent of primary care doctors in Michigan and nearly one million doctors and hospitals nationwide.

We appreciate the opportunity to provide comments on the Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs.

Section A: General Implementation Concerns

Reporting Limitations

Employer Group Reporting

Priority Health does not have access to all of the information requested for the reporting, specifically information relating to our self-funded employer groups as we only administer their benefits and do not have access to their member data (such as average monthly premium paid by employers on behalf on enrollees and average monthly premium paid by enrollees). The employers would each have to report this information to us for us to gather for the report. As another option, the Departments and OPM can gather this information from the Section 5500 filings that Cafeteria plan sponsors file every year.

Rebates

We experience reporting limitations from our Pharmacy Benefit Managers (PBMs) in relation to rebate data due to a lack of transparency. We do not receive timely claim level information on drug claims:

currently we are paid rebates quarterly; there is a four-month lag between when the quarter ends from when we are paid for the prior quarter. This can impact compliance around reporting rebate information.

The Departments have solicited comments on how manufacturer copay assistance programs and coupon cards should be accounted for within the statutory drug reporting requirement. Issuers and plan sponsors do not have this information as it is not collected at the point-of-sale by retail/brick-and-mortar pharmacies. Because the pharmacies do not report out how member cost-sharing is reduced or impacted by manufacturer discounts, there is no way issuers, plan sponsors or PBMs could report this level of data. This information, if mandatory, would require pharmacies to modify their point-of-sale transaction systems and produce additional reporting, which may be overly burdensome for smaller independent pharmacies.

Medical Injectables
We recommend that the Departments and OPM not request information related to medical injectables or drugs administered under the medical benefit such as those during an inpatient stay due to the lack of accurate claims detail we receive from providers. Currently, providers input inaccurate NDC codes to receive reimbursement, causing our claims data to report inaccurate information.

Initial Reports Enforcement
It will take our health plan time and collaborative effort with our PBM to collect the information requested to be reported. Additionally, our PBMs may be working with other health plans to gather the same information, potentially causing a delay in collecting this information in time for the initial report due date in December.

Additionally, due to the lack of guidance on the defined data elements to be reported, formatting of the report, and level to report this data on (i.e. health plan level, market, product, group level, etc.), Priority Health recommends that the reporting requirements not be heavily enforced for the first two cycles of reporting (Dec. 27, 2021 and June 1, 2022). This will allow us time to make a good faith effort to produce a preliminary report absent formal and timely rulemaking; it will also allow us time develop a process to produce future reporting once guidance is released. By June 2023 our health plan will have a process for reporting in place that will comply with the standards outlined by the Departments and OPM.

Section B: Definitions
Definition of "health care services"
The reporting requires inclusion of the costs of "health care services," a term which the Departments seek assistance in defining. In the interest of making use of existing reporting, we recommend using the MLR reported medical costs less the pharmacy costs as the reported amount for non-pharmacy health care services. Further, as this information is reported through MLR, the Departments could use MLR reports as the data source to address these requirements from PHS Act section 2799A-10, ERISA section 725, and Code section 9825.

Section C: Entities that Must Report
Aggregated Data
While Priority Health can submit data on behalf of multiple plans and coverage options, there are several issues in reporting pharmacy benefits and drug costs in this manner:

1. Reporting on a non-aggregated level would be burdensome as it would necessitate the generation of more than 7,000 reports annually from our membership alone. We note even the Section 6055 reporting is submitted to the Treasury from the issuer level rather than at the employer level for insured plans. There are about 31 million large and small business in the US. If this reporting requirement is expected of all group health plans in the US, having each group health plan submit data for each employer group for these requirements will be a lot of data for the Departments and OPM to collect, analyze, audit, and make use of for their own reporting/analysis purposes. In addition, many plan sponsors offer multiple plan offerings. It is feasible, therefore, that a single employer would be responsible for producing multiple reports if the "plan level" was defined narrowly.
2. Reporting at the market level (i.e., small group, large group) vs. the plan or even the employer level would be more realistic as it will preserve the privacy of plan members and reduce the risk of health plans violating HIPAA regulations since some employer groups are so small (i.e., 1 or 2 people) that it would be easy to discern which data elements apply to a particular person.

Because of this, we recommend that reporting be aggregated by group size (i.e., large group, small group) and product to keep reporting less burdensome, increase the usability of the data for the Departments and OPM, satisfy HIPAA compliance laws, and preserve the privacy of small group employees. Therefore, reporting for small employer HMOs and small employer PPOs would be submitted separately. The same would hold true for large employers. In this example, the Departments would be able to assess the impact of network size (open vs. closed networks) in costs.

The Departments are right to question the impact this reporting will have on self-funded employer plan sponsors. As noted above, many employers provide multiple plan offerings to their employees (such as a non-HDHP vs. an HDHP to reduce premium contribution costs. If self-funded employers are required to submit data at the plan-level versus as a collective single report from a single entity (the employer), this reporting will prove very costly and time-consuming for employers. As health care costs trend higher, more and more employers are seeking self-funded or partially-insured plans meaning the size of the employer is smaller than historically seen in the self-funded arena. We recommend the Departments consider removing the requirement for self-funded or partially-insured plan sponsors below 50 employees.

Self-funded providers will certainly turn to their third-party administrator and PBM for assistance in generating these reports. We recommend sufficient time following rulemaking is provided to allow the parties to contract services and delineate roles before submission of the first report.

Section D: Information to be Reported

Level of Detail of Information to be Reported

Priority Health recommends that the Departments and OPM define the data elements needed for the information requested in a manner that is not on a granular level, but on a broader level of detail (such as reporting on prescription drugs in general and not report on drugs administered in different care settings). Requesting a granular level of detail to be reported for different types of employer groups will be burdensome as it will take more time and resources to produce the initial report and every report thereafter. Additionally, such reporting reduces the privacy of our small group employees.

Prescription Drug Classes
We recommend that the Departments and OPM adopt the use of a prescription drug class that is a nationally recognized standard (such those used Medicare and FDB). Currently, Priority Health utilizes Medispan and recommends this standard.

Section E: Coordination with Other Reporting Requirements

Duplicative Reporting
The information the Departments and OPM request that we report on are similar to other reports we currently submit to the federal government. We recommend that the data elements that are collected as part of the IRS Section 6055 and 6056 reporting as well as the Schedule 5500 filings are not included in this new reporting.

Additionally, the Federal Employees Health Benefit Program (FEHB) currently submits a yearly report to OPM on prescription drug prices. We request that the FEHB program not be included as a part of these data elements.

Timeframe to be Reported
Because our different employer groups have different plan start and stop dates, the most consistent timeframe to report the requirements would be on a calendar year basis for the most recent calendar year (i.e. for the report due June 2022, we would report on information from Jan. 1, 2021-Dec. 31, 2021). Though inconsistencies will exist across plans with non-calendar year start and stop dates, this is the most consistent and less arduous way to report the information, as opposed to reporting according to each group health plans' start and stop dates.

Calendar-year reporting also lends itself to better inclusion of claims incurred but not received data. The inconsistencies in plan years also make the case for aggregating data at the market/product level rather than at the employer-plan-sponsor level.

Sincerely,

Christina Barrington
Vice President of Pharmacy Programs