Departments Issue Interim Final Rule on Group Health Plan Cost and Pricing Disclosure

Read time: 5 minutes

On November 17, 2021, the Internal Revenue Service (IRS), U.S. Department of Labor (DOL) and Health and Human Services (HHS) (collectively, the "Departments"), with the Office of Personnel Management (OPM), issued interim final regulations (IFR) to provide guidance regarding health care transparency provisions of the Consolidated Appropriations Act, 2021 (CAA). The IFR will apply to group health plans effective December 27, 2021. However, the Departments have announced a non-enforcement policy for the first year of applicability.

Background

In late 2020, Congress enacted the CAA, which added general transparency obligations on group health plans regarding accuracy of provider directories, information to be placed on insurance ID cards and requirements to ensure continuity of patient care when a provider switches from in-network to out-of-network during a course of treatment. The CAA also contained provisions targeting disclosure of plan pricing and cost information including specific requirements regarding prescription drug costs. The IFR specifically addresses plan obligation to report this information annually to the Departments.

What to Report

The CAA added parallel provisions to the Internal Revenue Code (Code), the Employee Retirement Income Security Act (ERISA), and the Public Health Service Act (PHSA) that will require group health plans to annually submit to the Departments certain information about prescription drug and health care costs and spending.

Plans will have to report:

- The beginning and end dates of the plan year.
- The number of participants, beneficiaries, or enrollees.
- Each state in which the plan is offered.

- The 50 most frequently dispensed brand name prescription drugs, and the total number of paid claims for each such drug.
- The 50 most costly prescription drugs by total annual spending.
- The annual amount spent by the plan for each such drug.
- The 50 prescription drugs with the greatest increase in plan expenditures from the plan year preceding the reported plan year, and, for each such drug, the change in amounts expended by the plan in each such plan year.
- Total spending on health care services by the plan broken down by the type of costs (including hospital costs; health care provider and clinical service costs, for primary care and specialty care separately; costs for prescription drugs; and other medical costs, including wellness services).
- Spending on prescription drugs by the plan as well as by participants, beneficiaries, and enrollees, as applicable.
- The average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers on behalf of participants, beneficiaries, and enrollees, as applicable.
- Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amounts of rebates and other remuneration under the plan from drug manufacturers during the plan year.
- Any reduction in premiums and out-of-pocket costs associated with these rebates, fees, or other remuneration.

The IFR specifies that plans will have to report all prescription drug rebates, fees and other remuneration received with respect to prescription drugs prescribed to participants, beneficiaries, or enrollees in the plan, from all sources (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, or vendor). This includes discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits. Further, the IFR requires plans to disclose service fees paid by a drug manufacturer to a pharmacy benefit manager (PBM) entity providing services to the plan that represent fair market value for a bona fide, itemized service performed on behalf of the manufacturer that the manufacturer would otherwise perform or contract for.

All plans will report information for the previous calendar year even if a plan has a non-calendar plan year.

Who Must Report

The requirements will apply to insured and self-funded group health plans, including private employment-based group health plans, non-federal governmental plans (such as plans sponsored by states and local governments), and church plans subject to the Code. The rules will apply to grandfathered plans but not to any health reimbursement arrangements (HRAs) or account-based plans. The IFR permits plans to require a third party (e.g., carrier, PBM, or third-party administrator) to report all required information on their behalf. However, any failure by a responsible third party will result in a plan being liable.

When Reports Are Due

The CAA requires plans to report calendar year 2020 information by December 27, 2021; calendar year 2021 information by June 1, 2022; calendar year 2022 information by June 1, 2023; and so forth. However, the Departments state in the IFR that they will not initiate enforcement action against a plan that does not report the required information by either the December 27, 2021, or June 1, 2022, deadlines. Instead, plans must submit reports for 2020 and 2021 by December 27, 2022. Plans should initiate an action plan to be prepared to meet the extended initial deadline.

Conclusion

The Departments plan to issue a reporting form with instructions that will detail the reporting elements and address the many outstanding questions plan sponsors have regarding these new requirements. Further, the Departments have announced that they will be developing an internet portal for electronic reporting. Additionally, the IFR might be modified after the Departments review public comments that may be submitted through January 22, 2022. So, stay tuned for more details as they develop.

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