July 23, 2021

Submitted via electronic filing: www.regulations.gov

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

Re: File Code CMS-9905-NC, Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs

Ladies and Gentlemen:

The Ohio Public Employees Retirement System (OPERS) appreciates the opportunity to provide comments in response to the Departments of Treasury, Labor, and Health and Human Services' (Departments) Request for Information (RFI) on the implementation of the reporting requirements included in the Consolidated Appropriations Act of 2021 (CAA).[1]

OPERS supports Congress' efforts to improve transparency regarding prescription drug costs and utilization and provide plan sponsors with leverage to negotiate lower prices for their participants. However, we have questions regarding the potential impact of these new reporting requirements on entities – like OPERS – that have embraced or are planning to transition to plans based on health reimbursement arrangements (HRA).

As suggested in the Departments' RFI, there may be certain types of health plans that are unable to reasonably or efficiently comply with the CAA's reporting requirements. Specifically, the Departments have requested information regarding the need for and impact of an exemption for individual coverage health reimbursement arrangements (ICHRA) or other account-based plans. OPERS appreciates the Departments' consideration of the unique challenges associated with applying the CAA's reporting requirements to HRA plans and asks that the Departments exempt these types of plans generally and stand-alone, retiree-only HRA plans, in particular.

Stand-alone, retiree-only HRAs and other account-based plans 1) will not be able to gather, aggregate, or report the required data without incurring significant costs and administrative burdens, 2) will not receive any benefit if they are required to comply with the CAA's reporting requirements, and 3) are not the primary source for the required information. If these plans are

[1] *See* Division BB, Title II, Section 204 of the Consolidated Appropriations Act of 2021, P.L. 116-260 (December 27, 2021).

not exempted from compliance with the CAA's reporting requirements, HRA plan sponsors and participants will be negatively impacted.

Background

OPERS is the 12th largest public pension fund in the United States, with a total net position of $114 billion as of the end of 2020. OPERS has more than 1 million members, approximately 216,000 of whom are retirees. Since 1973, OPERS has striven to provide its retirees with access to meaningful health care coverage though it is not required by law to do so.

Although the form and nature of OPERS' health care coverage has changed over the years in response to funding needs, rising costs for medical care and prescription drugs, and demographic trends, this evolution has accelerated over the past decade as OPERS sought to create a system of sustainable health care coverage for all of its retirees and began evaluating innovative new models of providing that coverage.

In late 2015, OPERS launched the largest retiree-only HRA plan in the United States for Medicare-eligible retirees and dependents who are enrolled in a Medicare plan through the OPERS Medicare Connector. OPERS' Medicare Connector, which replaced a Medicare Advantage plan that had experienced years of increasing costs and declining participation, provides significant financial support to retirees and their dependents by reimbursing qualified medical expenses, including Medicare premiums. Currently, the Medicare Connector has approximately 146,000 participants and is highly regarded within OPERS' Medicare-eligible retiree population.

With the experience gained from the successful transition to the Medicare Connector, OPERS began investigating the feasibility of creating a similar plan for its pre-Medicare population in 2019. In early 2020, the OPERS Board of Trustees voted to close OPERS' pre-Medicare self-insured group plan at the end of the 2021 plan year and establish a new retiree-only HRA plan (Pre-Medicare HRA plan) for retirees who are not yet eligible for Medicare.

As with the Medicare Connector, OPERS will offer its pre-Medicare retirees a stand-alone HRA from which they may seek reimbursement of their qualifying medical expenses. The Pre-Medicare HRA plan may reimburse qualifying medical expenses incurred in connection with several health care coverage options, including, but not limited to, individual plans selected from the Patient Protection and Affordable Care Act's (ACA) health care marketplace by the retiree themselves or with the assistance of a vendor hired by OPERS, a plan offered by any private health care insurance carrier, or an employer-sponsored group plan (either the retiree's or their spouse's).

As an early adopter of the HRA plan model – at least on this scale – OPERS has encountered a number of issues that have impacted the development and administration of its HRA plans. The earliest of these involved OPERS' ability to offer its retirees a stand-alone HRA plan in lieu of a traditional group health plan – not in addition to it.

Because a stand-alone HRA cannot satisfy the ACA's annual dollar limit and preventative health services requirements, and because OPERS sought to reward long-serving public employees, including law enforcement and public safety officers, it established a retiree-only HRA plan model for its Medicare Connector, and later, its Pre-Medicare HRA plan.

To maintain a retiree-only HRA plan model, however, OPERS must prohibit retirees who become employed during retirement by any public employer that contributes to OPERS from participating in the HRA during the period of their employment. This prohibition negatively impacts thousands of OPERS' retirees each year, in addition to the many public employers that seek to rehire OPERS retirees for a variety of hard-to-fill positions, including judges, custodians, poll workers, part-time law enforcement officers, and other variable and flexible hour positions.

In late 2018, OPERS shared these concerns, along with several recommendations for regulatory relief, in response to the Departments' proposed rules on HRAs and other account-based group health plans.[2] Following the issuance of the Departments' final rule in 2019, OPERS considered the new ICHRA plan model as a possible solution for allowing rehired retirees to participate in the Medicare Connector, but determined that it was unable to take advantage of the flexibility offered by the ICHRA because it sought to continue its core practice of determining health care allowances based on its retirees' age *and* years of service at retirement, both to incentivize longer periods of service and reward career public employees.

The final rule specified that the ICHRA must be offered to all current employees of each designated class on the same terms, and while exceptions were made for age and number of dependents, there was no consideration given to years of accumulated service credit. Moreover, the final rule was silent on whether "rehired retirees" would even constitute an acceptable class for purposes of satisfying the regulations. With approximately 3,700 covered employers, OPERS could not practically design an HRA that would comply with these class requirements.

When combined with the Departments' decision to leave in place all of the rules and eligibility criteria associated with retiree-only HRA plans, OPERS determined the ICHRA would not be a viable option and continued to foster its existing Medicare Connector and proceeded with the development of its new stand-alone, retiree-only Pre-Medicare HRA plan, which, as noted above, will open on January 1, 2022.

The OPERS Medicare Connector has been a tremendous success, with the overwhelming majority of OPERS members finding coverage that better suits their individual needs and at a more affordable cost than OPERS could have provided as a group plan sponsor. OPERS has every expectation that its new Pre-Medicare HRA plan will be equally successful and has spent the better part of two years educating and preparing its pre-Medicare retirees so that they may thrive under the new HRA plan model.

As noted above, OPERS supports the intent of the CAA's reporting obligations relating to

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[2] *See* comment letter from OPERS, https://www.opers.org/pdf/government/FederalResponses/2018/2018-12-27-OPERS-Comment-Letter-Treasury-Labor-Health-and-Human-Services.pdf (December 27, 2018).

pharmacy benefit and prescription drug costs; however, it will not be able to comply with them without expending significant resources that would otherwise be used to improve the sustainability of its HRA plans. As such, OPERS respectfully requests that the Departments exempt stand alone, retiree-only HRAs and other account-based plans from compliance with the CAA's reporting requirements. Alternatively, if the Departments are unwilling or unable to grant this exemption, OPERS asks the Departments to delay the implementation of the reporting requirements for stand-alone, retiree-only HRA plans because there are now no existing mechanisms, structures, or agreements in place to gather, aggregate, and report the data required by the CAA.

Comments Regarding the Applicability of the CAA's Reporting Requirements to Stand-Alone, Retiree-Only HRA Plans

OPERS respectfully requests that the Departments exempt stand-alone, retiree-only HRAs and other account-based plans from the CAA's reporting requirements for the following reasons.

1. Stand-alone, retiree-only HRA plans will have to expend significant amounts of limited resources to gather, aggregate, and report the data required by the CAA.

As discussed above, OPERS believes that there are certain types of account-based plans – particularly, stand-alone, retiree-only HRA plans – for which the CAA's reporting requirements should not apply, either because accessing the required data would be extremely difficult or result in considerable administrative expense.

OPERS' stand-alone, retiree-only HRA plans will incur substantial costs and experience significant administrative burdens – beyond those incurred or experienced by an ICHRA – in order to provide information that is more readily and efficiently available from the health plans selected by its HRA participants.

In establishing the ICHRA plan model, the Departments permitted HRAs to be integrated with individual health coverage and Medicare plans. While this change provided additional flexibility for employers that were considering whether HRA plans might suit their health care needs, it also established a link between the ICHRA and the individual health coverage offered to or chosen by the plan participant. The Departments specified that to be considered an ICHRA, the plan must meet several requirements, including ensuring and verifying coverage, identifying acceptable employee classes, and determining the identical deposits that will be made on behalf of each member of those classes. As a result, a connection remains between the ICHRA sponsor and the health care decisions made by its employees, retirees, etc.

In contrast, OPERS will soon sponsor two stand-alone, retiree-only HRA plans, which are further removed from the individual plan selections and experiences of its retirees. In 2019, the Departments confirmed that stand-alone, retiree-only HRA plans continue to be exempted from both ICHRA and HRA integration rules. As a result, there are additional degrees of separation between OPERS and the health care coverage decisions made by its HRA plan participants.

Generally speaking, as long as OPERS' retirees comply with the relevant rules of their respective HRA plan, OPERS will continue to fund their HRA accounts and reimburse qualified medical expenses; that is the extent of its involvement.

While we expect many retirees will continue to utilize OPERS' third-party administrator to consider coverage options and select a plan, no structure or mechanism has been established or even contemplated to gather data from the varied and scattered health plans from which OPERS' HRA plan participants can choose. Even in instances in which a retiree selects a plan through the third-party administrator, these plans operate in several different states, may utilize different pharmacy benefit managers (PBM), and may each gather or report the required pharmacy benefit and prescription drug cost data in different formats.

Further, no legal agreement or contract has been discussed to ensure that the required data is being gathered, aggregated in a consistent format, and provided according to statutory or regulatory timelines; and it is not clear that it would even be possible to reach such an agreement with the numerous health care providers available to OPERS' HRA plan participants. In short, if the Departments believe that compliance with the CAA's reporting requirements will be burdensome for ICHRAs or otherwise erode the flexibility they provide, the negative impact on stand-alone, retiree-only HRA plans will be worse.

Stand-alone, retiree-only HRA plans will be forced to pay immense costs to create an apparatus that gathers the required data from diffuse sources, standardizes that data, and then provides reports according to a set delivery schedule. Requiring stand-alone, retiree-only HRA plans to go to these lengths flies in the face of the flexibility the Departments hoped to introduce with the initial creation of the retiree-only HRA plan model and its later confirmation in the Departments' final ICHRA rules. Moreover, these expenditures would harm the solvency and sustainability of OPERS' post-retirement health care coverage, which are the concerns that drove OPERS to consider the HRA plan model in the first place.

2. <u>Neither stand-alone, retiree-only HRA plans nor their participants will receive any benefit if they are required to comply with the CAA's reporting requirements</u>.

As discussed in the Departments' RFI, the increased transparency afforded by the CAA's reporting requirements is intended to "enable plans and issuers to ultimately negotiate fairer rates and lower costs for participants, beneficiaries, and enrollees."[3] This is a laudable goal, and one that is supported by OPERS, which has long advocated for improvements to our nation's health care system, including removing obstacles to the development and market adoption of biosimilar drugs.

However, as the sponsor of what will soon be two stand-alone, retiree-only HRA plans, OPERS will not be able to realize these benefits because it will no longer engage in direct negotiations with PBMs or other entities for the purpose of setting its retirees' costs. Moreover, OPERS will

[3] Request for Information Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs, 86 Fed. Reg. 32,813 – 32,817 (June 23, 2021) (Discussing the purpose of the CAA's reporting requirements).

not be involved in the process of selecting the plan options from which its retirees can choose and will be completely separate from the process of setting formularies or determining the out-of-pocket costs paid by its retirees.

Despite the significant outlay of resources that will be necessary to comply with the CAA's reporting obligations, neither OPERS nor its retirees will receive any direct benefit in return. In fact, they will be worse off due to the diversion of funds that would otherwise be used to improve the solvency and sustainability of OPERS' HRA plans.

3. Stand-alone, retiree-only HRA plans are not the primary source for the information required by the CAA.

OPERS does not believe that exempting stand-alone, retiree-only HRAs and other account-based plans from the CAA's reporting requirements will impair or otherwise devalue the public's analysis of the collected pharmacy benefit and prescription drug cost data because that data can be more effectively and efficiently gathered from the various health plans selected by the plans' participants, rather than from the account-based plans themselves.

Requiring OPERS to act as a middleman, gathering and aggregating the required information, will not improve transparency or facilitate analysis. Rather, it will only impose significant cost and reduce flexibility for plans that have adopted stand-alone, retiree-only HRAs or other account-based plans to suit their health care needs.

The individual plans selected by OPERS' HRA plan participants will have direct access to utilization and formulary information and stand to benefit the most from compliance with the CAA because they can use the data to inform their future discussions with stakeholders, including negotiations regarding price and coverage. In contrast, OPERS' sole source of information would be the individual plans themselves (assuming it is even possible to access that information, which would be unlikely without individual agreements with every individual plan and approval by each retiree). Further, OPERS would have no ability to audit or confirm the information received from the individual plans except for the information OPERS already has obtained through the proper administration of the HRA, which is limited to the actual, out-of-pocket expense incurred by a retiree. This leaves OPERS with the prospect of providing a partial data set or data it could not reasonably be expected to obtain or confirm.

OPERS believes that it has created, through its third-party administrators, a thorough and robust system for substantiating that reimbursement requests are for qualified medical expenses. This process includes quality control and audit procedures. But, even with this process in place, OPERS will only have access to information regarding the cost that the retiree directly incurred – such as a prescription drug copay. OPERS would not have access to underlying cost data, nor would it have any need for this access through the process of substantiation and reimbursement. It is unlikely this partial data will provide any of the benefits contemplated under the CAA.

The appropriate source for a full data set would be the retiree's individual or employer-sponsored group health care plan, which are already obligated under the CAA to report that information. If OPERS' HRA plans were also required to report, they would have to: (1) Report a duplicative partial data set; or (2) Collect a full data set from each individual health care plan, which, if even possible, would include the creation of a complex and costly data collection structure, for the sole purpose of reporting duplicative data.

Additional Comments

Though OPERS firmly believes its HRA plans should be exempted from satisfying the CAA's reporting requirements, if the Departments are ultimately unable to grant this relief, OPERS will need additional time to assess how and whether it is even possible for a stand-alone, retiree-only HRA plan to gather, aggregate, and report the data required by the CAA. Understanding that the reporting deadlines were established in the statute itself, we ask the Departments to consider how to accommodate entities, like OPERS, that have reasonably adopted HRA plans in order to preserve health coverage for their retirees, employees, etc.

We appreciate the opportunity to provide comments in response to the Departments' RFI. Should you have any questions, or should you like to discuss our comments further, please contact the undersigned at 614-222-0050.

Sincerely,

Karen E Carraher

Karen Carraher
Executive Director