NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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The Honorable Xavier Becerra,
Secretary
U.S. Dept. of Health and Human Services

Ali Khawar
Acting Assistant Secretary
Employee Benefits Security Administration
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Carol A. Weiser
Benefits Tax Counsel
U.S. Dept. of Treasury

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Internal Revenue Service
U.S. Dept. of Treasury

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Re: Request for Information (RFI) Regarding Reporting on Pharmacy Benefits and Prescription Drug Costs CMS–9905–NC (86 FR 32813 (June 23, 2021))

Dear Secretary Becerra, Acting Assistant Secretary Khawar, Ms. Weiser, and Ms. Levy:

The National Coordinating Committee for Multiemployer Plans (NCCMP) appreciates the opportunity to submit comments concerning the requirement in the Consolidated Appropriations Act, 2021 (the "CAA") that group health plans submit significant information to the Departments concerning prescription drug costs and the impact on plan expenses. We provide specific comments on issues identified by the Departments, as well as other issues of concern to multiemployer plan sponsors. In addition, we request that plan sponsors be provided the opportunity to comment on proposed regulations and that guidance be published sufficiently prior to implementation of the prescription drug reporting requirements to allow plan sponsors sufficient time to adapt their contracts, systems, and resources to the new reporting process.

Background on the NCCMP and Multiemployer Plans

The NCCMP is the only national organization devoted exclusively to protecting the interests of the job-creating employers of America and their labor partners, as well as the more than 20 million active and retired American workers and their families who rely on multiemployer retirement and health and welfare plans. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role in providing retirement, health, training, and other benefits to America's working men and women and their families.

The NCCMP is a non-partisan, nonprofit, tax-exempt social welfare organization established under Internal Revenue Code ("IRC") Section 501(c)(4), with members, plans and contributing

employers in every major segment of the multiemployer universe. Those segments include the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, office employee, retail food, service, steel, and trucking industries. Multiemployer plans are jointly trusteed by employer and employee trustees.

The CAA, includes multiple new obligations on group health plans, including the prescription drug reporting requirements that are the subject of the RFI. As the Departments issue implementing regulations, we encourage consideration of the fact that burdensome costs can undermine the goal of providing high quality health care. Multiemployer health plans are essentially pools of workers' earnings held in trust under federal law for the exclusive purpose of providing benefits to plan participants and beneficiaries. The trust funds are funded entirely by collectively bargained employer contributions for which covered workers explicitly trade off wages through the bargaining process. In a very direct sense, workers pay for their health coverage. If a trust fund's costs increase, despite the trustees' best efforts at cost containment, the burden falls directly on the workers, as trustees may be faced with the need to reduce benefits or adjust eligibility rules to address new costs. The benefits of any new mandates concerning prescription drug reporting, and its administrative requirements must be carefully weighed against the costs to ensure that workers continue to receive real value for their health care dollars.

Specific Comments

1. General Implementation Issues

Plans that are self-administered may have a variety of administrators (enrollment administrators, medical plans, pharmacy benefit managers (PBMs) that need to come into compliance. Sponsors of multiemployer health plans, like most self-insured plan sponsors, consider control of prescription drug costs to be critically important. Plan sponsors have adopted significant efforts to control prescription drug costs. These efforts may include working with PBMs to implement controlled formularies, therapeutic management, and pharmacy benefit tiers. In addition, self-insured plans generally include the right to audit PBMs for contract compliance in contractual agreements, and closely monitor prescription drug cost controls. Plans regularly request information from their PBMs as to prescription drug cost-drivers.

However, the processes and contract provisions that are currently in place will likely need to be renegotiated to assure that the PBM will provide the health plan with the information necessary to comply with the reporting requirements under the CAA. Moreover, plan sponsors cannot appropriately amend contracts until regulatory guidance specifies what reporting obligations are required. In addition, if PBMs are to report directly to the Departments, plans will need time to delegate that responsibility to the PBM and negotiate the appropriate reporting relationships. Additional issues may arise when a plan changes PBMs, as information may be needed from the prior PBM with which the plan no longer has a contractual relationship.

The length of time needed to prepare and submit data will depend on, among other items, the complexity of the final components of the report, the number of sources from which data must be gathered, and the final format of the report, e.g., whether manual data gathering and/or entry or combining all reports from all data sources into a single file will be required.

2. Definitions

Plan sponsors will require clear definitions of terms on which reporting is required. Guidance should be issued in regulatory or subregulatory forms that are easily accessible to plan sponsors and their professional administrators. Guidance should not be issued in formats or forums where plan sponsors do not participate, e.g., guidance should not be issued through systems such as the HIOS system which group health plan sponsors are not able to regularly access.

Terms such as rebates and remuneration need to be clearly defined. Because of the annual nature of the reporting specified in the statute, reporting should be limited to that available to the plan sponsor for the reportable year and should not be required to be identified by the particular claim to which they are related. Plan sponsors should not have any obligation to reconcile information about rebates paid for a particular drug or beneficiary if payments are reconciled after the reporting year.

In defining report on rebate amounts, we would appreciate confirmation that reporting concerning rebates is limited to reporting rebates and other remuneration for the top 25 therapeutic classes and for drugs that yield the greatest amounts of rebates only, and not for reporting concerning the top 50 drugs by claim volume, dollar paid volume and top trending cost.

An additional challenge is defining the average monthly premium. Self-insured plans do not calculate a monthly average premium. Consequently, regulations should define how to determine this amount. In addition, the Departments should address which benefits the average monthly premium includes, e.g., just prescription drug or medical and other benefits as well.

3. Prevention of Duplication

We recommend that the Departments consider issuing rules concerning prevention of duplication with this regulation in the same manner as in the final transparency regulation. In that regulation, the Departments issued a rule preventing unnecessary duplication of disclosures with respect to insured coverage, which provided that a plan may satisfy the disclosure requirements if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and issuer.[1] Similar guidance would be appropriate with respect to the prescription drug reporting obligations for insured plan options.

4. Enforcement discretion

[1] 85 Federal Register 72244 (November 12, 2020).

The agencies should provide for enforcement discretion upon demonstration of good faith compliance. In the preamble to the Interim Final Regulation on the No Surprises Act (Part I), the Departments stated that plans are expected to implement the requirements using a good faith, reasonable interpretation of the statute, and that the Departments would issue guidance on their expectations concerning good faith compliance. We would welcome guidance on good faith compliance with all of the requirements of the CAA, including the prescription drug-reporting obligation.

Good faith compliance with the reporting requirements should give flexibility to plans in the absence of regulations regarding reporting details and format, which cannot be determined based on the statute alone. Flexibility is also needed to prevent multiple systems changes before regulations are finalized.

5. Regulations should be issued pursuant to the normal notice and comment process

We recommend that the Departments publish a Notice of Proposed Rulemaking with a sufficient comment period prior to publishing final regulations or interim final regulations. With a reporting obligation that is (1) complicated, (2) likely to involve multiple administrators, (3) expensive, and (4) likely to be one of several reporting requirements the Departments are implementing, e.g. air ambulance information, it is best to consider appropriate reporting options and select the most efficient method after obtaining information from interested parties. Comments submitted in response to the RFI may assist the Departments in crafting a proposed rule, but that is not substitute for having the opportunity to comments on the details of the reporting requirements in a proposed rule. This Unlike the surprise billing provisions contained in the CAA, which directly impact participants, there is no justification for an interim final rule with respect to this reporting requirement. In this case, excessive speed may interfere with the development of a comprehensive, usable reporting structure.

6. Effective date of regulations

We recommend that the effective date of final regulations should be sufficiently after the issuance of final regulations and any needed technical specifications to allow plan sponsors time to make the systems changes needed to implement these requirements.

Conclusion

The NCCMP looks forward to continuing to work with the Departments on this matter. Thank you for considering these comments. If you have any questions or would like to discuss these comments further, please contact Mariah Becker at 202-756-4637.

Regards,

Michael D. Scott
Executive Director