

July 23, 2021

(Sent via email: <https://www.regulations.gov/>)

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

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

Dear OHPSCA:

We submit the following on behalf of UNITE HERE HEALTH (the "Fund"), a national Taft-Hartley multiemployer health and welfare trust. As you are no doubt aware, our plans are nonprofit plans governed jointly by employer and union representatives for the exclusive benefit of the participants covered under the Fund. There are no shareholders or stock options. We rely on a combination of self-administered and vendor contracted entities to serve our members, who are a diverse population. All revenue and resources are used to operate our Fund to provide comprehensive benefits to the families covered.

In general, requiring the same reporting requirements for all entities regardless of size, structure or resources has a disproportionate impact on small nonprofit plans. The Fund appreciates the opportunity to offer comments on the new reporting requirements related to pharmacy benefits and prescription drug costs. We have organized our comments based on the topics and numbering in the request.

A. General Implementation Concerns, #3

As a multiemployer fund with over twenty (20) different plans of benefits and two pharmacy benefit managers ("PBM(s)"), this reporting will require significant new administrative resources, particularly regarding per plan requirements. The following areas require new administrative spend, which results in disproportional additional costs to small organizations, without improving member benefits.

50 prescription drugs with greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report and the change in amounts expended for each such drug. Rebates, fees and any other remuneration paid by drug manufacturers to the plan, its administrators or service providers, including amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates and other remuneration from drug manufacturers during the plan year.

- Since Plan years do not coincide with rebate aggregation and formulary change timelines, these requirements will require a separate and significant tracking system for Federal reporting. See suggestion below under section F regarding timelines.

Any reduction in premiums and out-of-pocket costs associated with the rebates, fees, or other remuneration.

- For small multiemployer plans, that may be difficult to determine since many plans of benefits have hourly contribution rates and there often is not a direct correlation to out-of-pocket expenses.

B. Definitions, #2 & #3

Drugs dispensed in non-pharmacy settings (e.g., inpatient, outpatient, office, home) are not covered under the prescription drug benefits. These are commonly covered through medical benefits, which are frequently administered by different entities with different contract terms. The required reporting elements are not readily available or easily combined with prescription drug data.

The spirit of the legislation appears to focus specifically on pharmacy benefits and the related drug costs rather than drugs covered under medical benefits. The applicable section of the Consolidated Appropriations Act, 2021 requiring this reporting is titled "Reporting on Pharmacy Benefits and Prescription Drug Costs," and the required data elements are relevant to prescription drug benefits and pricing through PBMs. Separately, under the final Transparency in Coverage Rule, plans are required to disclose similar pharmacy data as part of the machine readable files, producing largely duplicative data. Under the preamble of that Final Rule, the Departments recognized the operational challenges and burdens plans and issuers would have had if prescription drug pricing data was required to be combined with data from other sources. Those same operational issues would impact this reporting. As a result, we recommend the Departments explicitly limit the reporting requirement to drugs dispensed and covered by the plan's pharmacy drug benefit.

Furthermore, consistent with industry standards, prescription drugs should be identified by National Drug Codes (NDCs) or the first nine digits of the NDC. We currently are unable to report by RxCUI and would need more time and resources to obtain such data and comply with reporting by RxCUI. It is worth noting the Transparency in Coverage Final Rule requires NDC be reported on the machine readable files. The Departments should adopt a consistent approach across the board.

C. Entities that Must Report, #2, #3, #4; A. General Implementation Concerns, #4

The Departments sought information on multiemployer plan considerations, aggregation of data, and which entities house the necessary information. We encourage the Departments to provide flexibility to reporting entities to determine whether aggregation works best for that entity in whole or in part. As noted above, we have multiple plans of benefits and currently use two PBMs. It would be helpful to aggregate the data under each of the PBMs, but it would be

burdensome and time consuming to aggregate data across the entire fund, especially given certain reporting elements (i.e., top 50 most frequently dispensed, costly, etc). In addition, it would be burdensome if we were required to report by State or market.

We strongly recommend the Departments allow for plan service providers to submit data on behalf of plans and to allow for reporting to be completed in separate parts or modules. For example, a PBM or TPA for prescription drug benefits will have a lot of the prescription drug information but will not have the required healthcare cost data or general plan information.

D. Information Required to be Report, #9

We recommend rebates and fees be reported at the total level, rather than broken out by subcategories. If subcategory reporting is required, the time and resources to comply will increase substantially and cooperation from our service providers will be required.

F. Public Report and Privacy Protections #3

Reporting on the previous plan year by June 1 of each year will be problematic for plans whose plan year closes during the first half of the year. For example, our plan year is 4/1 - 3/31. There is not sufficient time to prepare and submit the required information. In addition, it would not be possible to include complete information on rebates, which generally have a six-month lag. We recommend the Departments adopt a reporting deadline that provides plans with at least six months to gather the necessary data. Reporting on the prior calendar year or the prior plan year ending in the calendar year would be feasible if the deadline were moved to July 1 of each year.

The Fund values the opportunity to provide comments on the implementation of the new reporting requirements. We hope the Departments will provide greater flexibility with regard to the reporting. Please do not hesitate to contact us if you have any questions about our comments or need additional information.

Very truly yours,

UNITE HERE HEALTH

Matthew Walker, CEO