



July 23, 2021

UPMC Health Plan

Legal Services Department

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The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Attention: **(RIN 0938-AU66)**
200 Independence Ave., SW
Washington, D.C. 20201

Submitted electronically via <http://www.regulations.gov>

Re: Request for Information: Reporting on Pharmacy Benefits and Prescription Drug Costs (RIN 0938-AU66)

Dear Secretary Becerra,

UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments in response to the Departments of Health and Human Services (HHS), Labor, the Treasury, and the Office of Personal Management (collectively, "the Departments") **Request for Information: Reporting on Pharmacy Benefits and Prescription Drug Costs**, as published in the Federal Register at 86 FR 32813 (the "RFI").

UPMC offers a wide range of commercial group and individual, Medicare, Medicaid, CHIP, and ancillary coverage products to consumers in Pennsylvania, West Virginia, and Ohio. Since beginning operations in 1996, UPMC has been recognized for its dedication to quality and the provision of outstanding customer service across its product lines, which collectively provide commercial or government programs coverage to more than 4 million members. UPMC has offered consumers a variety of coverage options as a QHP issuer since the launch of the Marketplace in 2014, and currently provides coverage to approximately 113,000 Marketplace enrollees. In several Pennsylvania counties, UPMC is the only QHP issuer currently offering a product through the Marketplace.

We thank the Departments for providing QHP issuers and other stakeholders an opportunity to comment on reporting requirements under the Consolidated Appropriations Act, 2021 (CAA). UPMC supports the Departments in their ongoing efforts to improve transparency and lower the price of prescription drugs. It is with this support in mind that we respectfully offer the following comments on selected provisions of the RFI.

Addressing the Underlying Cost of Prescription Drugs

The CAA establishes new requirements for group health plans and issuers offering group or individual health insurance to report on certain pharmacy benefits and drug costs on an annual basis. Information to be reported includes the 50 most costly prescription drugs, the 50 prescription drugs with the greatest increase in plan expenditures over the plan year and the impact on premiums by rebates, fees, and other remuneration paid by drug manufacturers to the plan. The Departments intend to analyze this information and issue a report in an effort to assist plans and issuers in negotiating fairer rates and lower drug costs for participants, beneficiaries, and enrollees. While this report could provide valuable insight into specific cost drivers of high prescription drug spending, to effectuate a meaningful and lasting reduction in the cost of prescription drugs, increased focus should be placed on high drug manufacturer list prices. Prices for prescription drugs are directly set by pharmaceutical manufacturers who have continued to dramatically raise prices year over year. Without action, pharmaceutical manufacturers will continue this trend, thereby increasing the dollar amount consumers will need to devote towards purchasing essential medication. While we believe that the Department's report will be helpful in identifying specific high-cost drugs, we encourage the Departments to tackle the underlying root cause of high-cost drugs by addressing drug manufacturer's rapid and compounding increase of list prices through future administrative action.

Finalize Regulations Before Implementing Required Reporting

Group health plans and issuers offering group or individual coverage must submit to the Departments the information required under the CAA by December 27, 2021, and no later than June 1 of each year thereafter. The Departments have indicated that regulations will be released in the future to formally establish technical reporting standards. However, to date, no additional compliance guidance or regulation has been issued. There are a number of outstanding operational details that must be established before organizations are able to effectively comply with the reporting requirements. These include creating a reporting system to submit the required information to the Departments, establishing a preferred format for submitting the data, establishing specific details and data parameters on information that must be newly reported, and also establishing whether reporting entities can submit aggregated data as opposed to reporting information separately for each group health plan. These specifications should be established well in advance of the date on which reporting entities are asked to comply with the reporting requirements of the CAA. Once operational details have been finalized by the Departments through rulemaking, reporting entities will need sufficient time to ensure compliance with all established requirements. While this area of new reporting appears on its face to be reasonably discrete, we note that this requirement is being implemented at the same time that group health plans and health insurance issuers are facing a litany of new requirements with respect to price transparency, interoperability, and surprise billing, in addition to other changes under

the CAA that will require new processes and procedures for maintaining provider directories, preparing member ID cards, and preparing new broker and agent compensation disclosures, among others. Given that these new requirements are all competing for similarly expedited implementation projects among finite plan operational/IT staff and resources (as well as limited resources among credible industry technology and data solution vendors when responding to numerous new and significant, industry-wide requirements), we urge the Departments to take a measured approach to implementation of the new reporting requirements related to pharmacy benefits and prescription drug costs. To this end we ask that: (1) the Departments delay the reporting date until at least six months after a final rule establishing the reporting process has been published in the Federal Register, and (2) that consideration be given to affording plans a one (1) year window of good faith compliance.

Align Reporting Requirements with Other Federal Programs

A number of data elements that group health plans and issuers must report on under the CAA are also required to be reported on by issuers participating in federal insurance programs such as Medicare and may be required to be reported on under various State laws and regulations. As such, many entities subject to the new CAA requirements will have had prior reporting experience with similar reporting for other federal and state programs. Aligning CAA reporting requirements with existing federal and state reporting requirements to the greatest extent possible will make it easier for entities to comply with the new requirements and will decrease administrative burden by building on existing reporting standards rather than creating entirely new ones. We recommend that the Departments adopt such an aligned approach in future rulemaking.

Reporting Safe Harbor

Group health plans and issuers offering group or individual coverage often utilize Third-Party Administrators (TPA) and Pharmacy Benefit Managers (PBM) to help manage their prescription drug benefits. In their capacity as administrators, TPAs and PBMs collect and store certain data on behalf of issuers and health plans, including information that the Departments will now require issuers and health plans to report on. In many cases, issuers do not have direct access to data held by TPAs and will need to work with these entities to obtain access. Gaining access to this information could require the renegotiation of contracts, workflows, and/or system and reporting protocols between TPAs and issuers. In some instances, plans and issuers may not have direct access to the required data at all; insofar as this will impair the ability of plans and issuers to directly submit relevant data to the Departments, addressing the otherwise applicable reporting requirements will require new and additional operational coordination with TPAs or PBMs. As the Departments proceeds with rulemaking, we ask that the Departments acknowledge the inherent challenges of

reporting on such data and afford appropriate flexibility in final reporting or data submission protocols to allow for joint or concurrent data submissions where plans do not have direct access to the information being requested.

Impact on Premiums

A unique element of the newly required reporting is the impact on premiums by rebates, fees, and other remuneration paid by drug manufacturers to the plan. Although plans and issuers certainly consider the anticipated value of rebates or other payments from drug manufacturers when calculating premiums or establish plan cost-sharing parameters, this type of calculation is only one small factor in the complex and multi-variate analysis that establishes premiums or cost sharing under a particular plan. As such, there are practical limits on the granularity with which plans and issuers hold and incorporate rebate-related financial projections and it is often not the case that rebates for any given drug are mapped or allocated in a direct way to a specific aspect of plan design or impact to plan premiums. Rather, this type of exercise typically happens in the aggregate, and the inherent fungibility of money belies the notion that a change to any given manufacturer rebate amount can be tied to a specific impact on plan pricing or benefit design. While we appreciate the Department's charge in establishing appropriate reporting parameters related to the impact of rebates or other manufacturer payments to plans, we urge caution in attempting to establish or collect overly granular data elements that may not actually exist or be utilized by actuarial or underwriting staff when establishing plan premiums and/or cost sharing designs. We encourage the Department to afford plans reporting flexibility in this area, based on the manner in which a given plan or issuer actually incorporates rebate and other manufacturer payments into its premium and plan design methodology, and to expressly establish allowances for reporting this type of financial data at an aggregate level by market.

We again thank the Departments for affording issuers and other stakeholders the opportunity to provide input on their request for information on new reporting requirements under the CAA. We appreciate your consideration of our comments and look forward to continued collaboration with the Departments in the future.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'C.B. Wallace', with a stylized flourish at the end.

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Assistant Counsel
UPMC Health Plan