ApexBenefits

Compliance Overview

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No Surprises Act: Transparency Reporting Pharmacy & Drug Costs

The No Surprises Act (NSA), enacted as part of the Consolidated Appropriations Act, 2021 (CAA), includes transparency provisions requiring group health plans to report information on prescription drugs and health care spending to the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments). This requirement applies to group health plans and health insurance issuers in the individual and group markets but does not apply to account-based plans and excepted benefits.

The NSA required the report be provided by Dec. 27, 2021, and by June 1 of each year thereafter. However, an interim final rule deferred enforcement of the initial deadline to **Dec. 27, 2022**. The Departments strongly encourage plans and issuers to start working to ensure that they are in a position to be able to report the required information. The Departments further encourage plans and issuers that are able to submit the required information by either the Dec. 27, 2021, or June 1, 2022, statutory deadlines to do so.

LINKS AND RESOURCES

- On Nov. 23, 2021, the Departments published an interim final rule regarding the requirement to report pharmacy and drug costs.
- Transparency in coverage FAQs were released on Aug. 20, 2021.

Reporting on Pharmacy Benefits and Drug Costs

The NSA requires group health plans and health insurance issuers offering coverage in the group and individual markets to report certain information on plan medical costs and prescription drug spending to the Departments. Specifically, plans must report the following:

- General information on the plan or coverage, such as the beginning and end dates of the plan year, the number of participants, beneficiaries or enrollees (as applicable), and each state in which the plan or coverage is offered;
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan and the total number of paid claims for each drug;
- The 50 most costly prescription drugs with respect to the plan by total annual spending and the annual amount spent by the plan for each drug;
- The 50 prescription drugs with the greatest increase in plan expenditures over the prior plan year and, for each drug, the change in amounts expended by the plan in each plan year;
- Total spending on health care services by the group health plan, broken down by the type of costs; the average monthly premium paid by employers (as applicable) and by enrollees; and any impact on premiums by rebates, fees and any other remuneration paid by drug manufacturers to the plan; and
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration.

The majority of this information may be submitted on an aggregate basis across plans in the same state and market segment. However, the following information cannot be aggregated and must be reported separately for each plan:

- Identifying information for plans and issuers and other reporting entities;
- The beginning and end dates of the plan year;
- The number of participants, beneficiaries or enrollees, as applicable, covered on the last day of the year; and
- Each state in which a plan or coverage is offered.

Reporting Entities

This reporting requirement applies to both grandfathered and non-grandfathered group health plans and health insurance issuers in the individual and group markets. However, it does not apply to account-based plans (such as health reimbursement arrangements) and excepted benefits.

Plans and issuers may satisfy these reporting obligations by having third parties—such as issuers, third-party administrators (TPAs) or pharmacy benefit managers (PBMs)—submit some or all of the required information on their behalf. To do this, a plan or issuer must enter into a written agreement with the third party providing the information on its behalf in accordance with the interim final rules. Group health plans are not prohibited from reporting the required information on their own, but the Departments expect this to be rare.

- If the issuer of a fully-insured group health plan is required by written agreement to report the required information but fails to do so, then **the issuer—not the plan—violates the reporting requirements.**
- If a fully-insured or self-funded group health plan or an issuer offering group or individual health coverage requires another party (such as another issuer, a PBM, a TPA or other third party) to report the required information by written agreement but the third party fails to do so, then **the plan or issuer violates the reporting requirements**.

Reporting Deadlines

This is an annual reporting requirement; plans and issuers will generally submit these reports in June each year, reporting information for the prior calendar year. The NSA required the report be provided by Dec. 27, 2021, and by June 1 of each year thereafter. However, the Departments anticipate that plans and issuers may need additional time to:

- Modify contractual agreements to enable disclosure and transfer of the required data between various entities;
- Develop internal processes and procedures; and
- Identify, compile, prepare and validate the required data.

As a result, the Departments deferred enforcement of the initial reporting requirement to **Dec. 27, 2022**. The first annual statutory reporting deadline is **June 1, 2022**. The Departments strongly encourage plans and issuers that are able to submit the required information by either the Dec. 27, 2021, or June 1, 2022, statutory deadlines to do so. HHS encourages states that are primary enforcers of this requirement with regard to issuers to take a similar enforcement approach and will not determine that a state is failing to substantially enforce this requirement if it does so.