July 28, 2022

Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Re: Information Collection Request – Prescription Drug and Health Care Spending
(OMB Control Number: 0938–1405)

Submitted Electronically: www.reginfo.gov

Dear Sir/Madam:

UnitedHealthcare (UHC) is submitting comments in response to an Information Collection Request (ICR) related to instructions for submitting annual reports on prescription drug benefits and health care spending to the Departments of Health and Human Services, Labor, and the Treasury and the Office of Personnel Management. Submission of this report by health insurers, group health plans, and Federal Employees Health Benefits (FEHB) plan carriers will be administered by the Centers for Medicare & Medicaid Services (CMS). The ICR was published in the *Federal Register* on June 28, 2022 (87 FR 38411) and July 15, 2022 (87 FR 42484).

UHC is dedicated to helping people live healthier lives and making the health system work better for everyone by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. In the United States, UHC offers the full spectrum of health benefit programs for individuals, employers, and Medicare and Medicaid beneficiaries, and contracts directly with more than 1.3 million physicians and care professionals, and 6,500 hospitals and other care facilities nationwide.

UHC appreciates efforts by CMS to work with stakeholders to streamline the reporting process which impacts hundreds of reporting entities that are required to submit data on behalf of several million group health plans. In particular, we want to express our support for proposed revisions to the Report Instructions addressing issues we raised in prior comments – reporting the share of premiums paid by employers and employees and clarifying the types of claim costs included in different categories of health care spending (e.g., primary vs. specialty care).

There are, however, continuing challenges faced by certain reporting entities that must obtain data from a group plan sponsor to complete the report. The Report Instructions make clear that a group plan may not have different vendors complete the same data file (Report Instructions, p. 8). The challenge is where a service provider is submitting a data file that incorporates information from the plan sponsor or another group health plan vendor such as the plan Form 5500 number, stop-loss premiums or claims for wellness benefits. Another issue relates to terminated group health plans and the difficulty in obtaining data from a sponsor who no longer has a contractual relationship with the insurer or service provider that will be submitting a report on behalf of the plan.

We discuss below three types of information that must be obtained by a service provider from the plan sponsor or another vendor for inclusion in reports submitted on behalf of a group health plan – (a) employer and employee premium splits; (b) group health plan names and Form 5500 numbers; and (c) claims and premiums administered by other vendors of a group health plan. We offer recommendations on ways CMS can further revise the Report Instructions, or issue companion guidance, to provide reporting entities with flexibility in meeting their reporting obligations and address potential information gaps resulting from missing data.

Premium Splits

As we and other stakeholders have noted in prior comments, it is an industry practice to not collect information from a group plan sponsor on the amount of premiums paid by the employer and the employee. We want to favorably note CMS' recognition of these challenges in the revised Report Instructions which indicate that "the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in RxDC report for the 2022 reference year and all future reference years." (Report Instructions, p. 23). In addition, the "Response to Comments" document included as part of the ICR addresses situations where premium information may be difficult to obtain if the plan sponsor has terminated coverage with an insurer or service provider by noting "for the 2020 and 2021 reference years only, we revised the instructions to accept estimated values when, despite a good faith effort, an issuer has been unable to obtain the information from a former client." (Response to Comments, p. 4).

CMS should recognize that it will be challenging for service providers to receive complete 2022 reference year premium information from all group health plan clients. In addition, reporting entities should not be penalized if the plan sponsor refuses to provide premium information when requested. UHC urges CMS to take additional steps to address this potential information gap by: (a) continuing the enforcement safe harbor for the 2022 reference year (i.e., the report due by June 1, 2023) and (b) giving reporting entities the option to estimate premium splits in a particular state/market for any reference year if they are unable to obtain information from plan sponsors after good faith efforts to collect the data (and indicating the source of the estimate in the report narrative).

Group Health Plan Names/Form 5500 Numbers

We recognize CMS is requesting the plan name and Form 5500 number to ensure reports are submitted for all group health plans. As we have noted in prior comments, service providers generally do not submit Form 5500 reports on behalf of group health plan clients and do not maintain this information. Additionally, the service provider administrative services agreement may reflect the name of the plan sponsor and not the benefit plan name. As a result, there may be situations where the group plan name or Form 5500 number may not be readily available.

UHC recommends that CMS provide an enforcement safe harbor in the case of a data file submitted by a service provider on behalf of a group health plan if the service provider is unable to obtain the group health plan name or Form 5500 number after a good faith attempt. This safe harbor should be in effect with respect to reporting data for the 2020, 2021, and 2022 reference years.

Information Obtained from Other Plan Vendors

As noted, a service provider may be submitting a data file that includes information for services provided to the plan by another vendor to the group health plans. For example, stop-loss premiums are incorporated into the premium equivalent data (Report Instructions, p. 22), behavioral health and substance use disorder hospital costs are part of the hospital claim data field (Report Instructions, p. 26), and claims for wellness services are included in other medical costs (Report Instructions, p. 29). According to the report instructions the plan sponsor will need to forward information obtained from these vendors to the service provider responsible for reporting:

3.4 What if a vendor can't fill out an entire file?

Plans, issuers, carriers, and their reporting entities must work together so that each data file submitted in HIOS contains all required information. If one reporting entity is responsible for only some of the fields in a data file, it should fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS

(Report Instructions, p. 9).

As a result, the reporting entity is reliant on the sponsor obtaining the information and forwarding it in a timely manner for inclusion in the data file. In some cases, the sponsor (or their vendors) may be reluctant to share data given the competitive nature of information (e.g., giving the service provider, which also sells stop-loss coverage through an affiliated entity, information on stop-loss premiums paid to another insurer).

UHC asks CMS to provide flexibility for service providers that are unable to obtain information from a plan sponsor related to services provided by another plan vendor. We recommend that the Report Instructions or guidance indicate that the service provider will not be penalized if they make good faith efforts to obtain such information for inclusion in the data file, however, the plan sponsor refuses or otherwise fails to timely provide the data.

In addition, we recommend CMS consider ways to rationalize the reporting process to allow different vendors to submit data file information separately on behalf of the same group health plan. For example, the instructions could be revised to explicitly permit multiple vendors to provide information on a single data file report or the data files modified to collect different subsets of data (e.g., a separate report for stop-loss insurance premiums).

UHC appreciate the opportunity to provide these comments and recommendations. Please feel free to contact me if you have any questions.

Sincerely,

Christine McCartney Harris
Vice President and General Manager
Enterprise Performance Operations