

Overview of Consolidated Appropriations Act Rx Reporting

Section 204 of the Consolidated Appropriations Act (CAA) requires group health plans and health insurance issuers to report information about prescription drug pricing (including rebates) and health care spending, referred to as the RxDC report, to the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury. The Centers for Medicare & Medicaid Services (CMS) is collecting the submissions on behalf of these departments. The agencies will use this information to identify prescription drug trends and compile a biannual report to Congress (publicly available). The overarching goal of this requirement is to make drug pricing more transparent in order to lower drug costs for individuals.

Who must report ?

Health plans offering group or individual health insurance coverage, except for church plans, must report plan specific prescription drug spending and medical cost data annually to the Departments of Health and Human Services, Labor, and the Treasury. This applies to insured plans and self-funded plans. Excepted benefit plans (e.g., vision, dental, hospital indemnity, etc.), health care spending accounts (e.g., HRAs, HSAs, etc.), Medicare Advantage, Medicare Part D, Medicaid, SCHIP and Basic Health Program plans are not required to comply with this requirement.

What must be reported?

Plans and health insurers in both the group and individual markets are required to submit certain information on prescription drug and other health care spending to the departments annually, including:

- General information identifying the insurer, plan sponsor or plan
- Enrollment and premium information, including average monthly premiums paid by employees and the employer plus information about total life years
- Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services) by enrollees and employer or issuer
- Prescription drug spending by enrollees versus employers and issuer
- The 50 most frequently dispensed brand prescription drugs paid for by the plan

- The 50 highest cost prescription drugs paid for by the plan by total annual spending
- The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous plan year (includes the change in cost spent for each drug)
- Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs with the highest rebates and other price concessions
- The impact of prescription drug rebates, fees, and other remuneration paid by prescription drug manufacturers on premiums and out-of-pocket costs.

What are the required files?

Fully insured, Self-funded and group health plans must submit the following Plan Lists and Data Files:

- P2 Group health plan list
- D1 Premium and Life-Years
- D2 Spending by Category
- D3 Top 50 Most Frequent Brand Drugs
- D4 Top 50 Most Costly Drugs
- D5 Top 50 Drugs by Spending Increase
- D6 Rx Totals
- D7 Rx Rebates by Therapeutic Class
- D8 Rx Rebates for the Top 25 Drugs

When does the CAA reporting for pharmacy benefits and costs begin?

The first report is for calendar years 2020 and 2021 and is due no later than Dec. 27, 2022. Calendar year 2022 reporting is due no later than June 1, 2023. Future plan year reporting will be due by June 1 of the subsequent year.

Generally, this information must be aggregated at the state/market level, rather than separately for each plan. Examples: Insured individual, Insured small group, Insured

large group, Self-funded small group, Self-funded large group. Insured group business is reported for the state where the contract is issued. Self-funded group business is reported for the state where the plan sponsor has its principal place of business.

Currently, the CAA reporting requirement does not contain good faith compliance relief available for plans and insurers that make a good faith effort to comply with the law. The only relief currently available was issued via the [updated submission instructions](#) dated June 29, 2022. The instructions provide that enforcement action will not be taken for the 2020 and 2021 reporting year related to obtaining average monthly premiums paid by employers and employees.

PreferredOne is working to have 2020 and 2021 information available by the end of October/early November.

Where must the insurer or health plan submit the pharmacy coverage and cost report?

The report must be submitted to the Departments of Health and Human Services, Labor, and the Treasury (Tri-agencies). PreferredOne Insurance Company plans to submit the reports for its fully insured line of business. PreferredOne Administrative Services plans to submit the complete report for pharmacy and medical coverage that is not carved out. Self-funded customers with carved out pharmacy benefits will need to work directly with their PBM for the reporting of pharmacy benefit information (D3-D8), and PreferredOne will submit reports for the medical information (D1 and D2).

Carve-out Rx:

- P2: PBM Name & PBM EIN
- D1: Rx Under Pharmacy Benefits portion of Claim Costs
- D2: Rx Under Pharmacy Benefits
- D3-D8

Carve out Stop Loss and/or Wellness:

- D1: Stop Loss Premium Paid
- D2: Wellness Services

How are reports organized for self-funded groups when PreferredOne Administrative Services submits data?

PreferredOne will provide the data as requested per the CMS documented instructions. The reporting will be aggregated at the issuer/TPA/state/market level, rather than separately for each plan. The guidance provides uniform standards and definitions, including standards for identifying prescription drugs regardless of the dosage strength, package size, or mode of delivery so the Tri-Agencies may conduct meaningful data analysis and identify prescription drug trends.

- Data for fully insured groups will be organized separately by state for individual, small group and large group.
- Data for fully insured groups must be reported for the state where the contract is issued.
- Data organization for ASO plans are differentiated by ASO small group, ASO large group
- Data for ASO plans must be reported for the state where the plan sponsor has its principal place of business.
- Example of P2 data:

Group Health Plan Name	Group Health Plan Number	HIOS Plan ID	Form 5500 Plan Number	States in which the plan offered	Market Segment	Plan Beginning Date	Plan End Date	Members as of 12/31	Plan Sponsor Name	Plan Sponsor EIN	Issuer Name	Issuer EIN	TPA Name	TPA EIN	PBM Name	PBM EIN
------------------------	--------------------------	--------------	-----------------------	----------------------------------	----------------	---------------------	---------------	---------------------	-------------------	------------------	-------------	------------	----------	---------	----------	---------