Health Care Overview

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Prescription Drug Reporting (RxDC Report)

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.

This reporting process is referred to as the "prescription drug data collection" (or "RxDC report"). The first RxDC report was due by **Dec. 27, 2022** (covering data for 2020 and 2021); however, the Departments provided a **submission grace period through Jan. 31, 2023**, for this first report. The second RxDC report is due by **June 1, 2023**, covering data for 2022.

According to interim final rules, employers may use issuers, third-party administrators (TPAs), pharmacy benefit managers (PBMs) or other third parties to submit the RxDC reports on their behalf. The Departments have stated that, although employers can submit these reports on their own, they expect it will be rare for employers 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.
- An FAQ about the submission grace period and reporting flexibilities for 2020 and 2021 data was released on Dec. 23, 2022.
- More information, including RxDC reporting instructions, is available through the HHS' RxDC website.

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.

According to the Departments, this data will help them identify major drivers of prescription drug and health care spending, understand how drug rebates impact premiums and out-of-pocket costs, and promote transparency in prescription drug pricing.

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, TPAs or 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 self-funded group health plan requires another party (such as 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.** Thus, employers with self-funded plans should monitor their TPA's or PBM's compliance with the RxDC reporting. Unlike fully insured plans, the legal responsibility for RxDC reporting stays with a self-insured plan even if its TPA or PBM agrees to provide the report on its behalf.

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 deferred enforcement of the initial reporting requirement to **Dec. 27, 2022**. The Departments then provided a **submission grace period through Jan. 31, 2023**, so long as plans and issuers make a good faith submission of 2020 and 2021 data on or before that date.

Going forward, the annual deadline is June 1 of the calendar year immediately following the reference year. This means that the second RxDC report is due by June 1, 2023, covering data for 2022.

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