PRESCRIPTION DRUG REPORTING (RxDC)

DUE JUNE 1, 2023

Prescription Drug Reporting (RxDC Report)

Due June 1, 2023

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"). While the first RxDC report was due by December 27, 2022 (covering data for 2020 and 2021), the Departments provided a submission grace period through January 31, 2023, and did not consider a plan or issuer to be out of compliance if a good faith submission was made on or before that date.

This is an annual reporting requirement; plans and issuers will generally submit these reports by **June 1st** each year, reporting information for the prior calendar year. This means that the second and next RxDC report is due by **June 1, 2023, and will cover data for 2022.**

LINKS AND RESOURCES

- Prescription Drug Data Collection (RxDC) Instructions
- Prescription Drug Data Collection (RxDC) FAQ
- 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;

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- 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.

Group health plans 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 group health plan 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 if they so choose.

- 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 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 by June 1 each year, reporting information for the prior calendar year. The first report was due by December 27, 2022 (deferred enforcement until January 31, 2023) for 2020 and 2021 calendar year data.

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, and will cover data for 2022.