PRESCRIPTION DRUG REPORTING (RxDC)

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Group health plans and health insurance issuers must annually submit detailed information on prescription drug and health care spending to the Centers for Medicare & Medicaid Services (CMS). This reporting is referred to as the "prescription drug data collection" (or "**RxDC** report**"**)**.** 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 next RxDC report is due by June 1, 2025, and will cover data for the 2024 calendar year.**

The RxDC report is comprised of several files, including those that require specific plan-level information, such as plan year beginning and end dates and enrollment and premium data. It also includes files that require detailed information about medical and pharmacy benefits.

Most employers contract with third parties, such as issuers, third-party administrators (TPAs) and pharmacy benefit managers (PBMs), to submit RxDC reports on behalf of their health plans. Employers may work with multiple third parties to complete the RxDC report for their health plans. For example, a self-insured employer may use both its TPA and PBM to submit different portions of the RxDC report. A health plan's submission is considered complete if CMS receives all required files, regardless of who submits them.

LINKS AND RESOURCES

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

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 by June 1st each year, reporting information for the prior calendar year. The annual deadline is **June 1** of the calendar year immediately following the reference year. This means that the **data for the 2024 reference year must be reported by June 1, 2025.**

Action Steps

Employers should start reaching out to their issuers, TPAs or PBMs, as applicable, to confirm that they will submit the RxDC files for their health plans by June 1, 2025. Employers should also confirm that their written agreements with these third parties address this reporting responsibility.

Also, employers will likely need to provide their third-party vendors with plan-specific information, such as enrollment and premium data, to complete their RxDC submission. Employers should watch for these vendor surveys and promptly provide the requested information. Because employers with self-funded plans are ultimately responsible for RxDC reporting, they should monitor their TPAs' or PBMs' compliance with this reporting requirement.

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