THE DEEP DIVE
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CAA DEEP DIVE SERIES: NEW REPORTING REQUIREMENT RELATED TO PHARMACY BENEFITS AND OTHER PLAN COSTS

The Consolidated Appropriations Act (CAA) creates a dramatic new reporting requirement that applies to group health plans of any size (except for church plans). The new reporting is like a Form 5500 in that it is a mandatory annual filing for health plans. However, it is dramatically different because it applies regardless of plan size and reports in detail on actual plan expenditures.

To date, no official guidance has been issued relating to these reports, even though the first set of filings are due by December 27, 2021. Thereafter, the filings will be required annually by June 1.

The reports will be required to include:

- The plan year;
- The number of plan participants;
- A list of each state in which the plan is offered;
- The 50 drugs prescribed most frequently along with the total number of prescriptions filled for each;
- The 50 drugs the plan spent the most on and the amount spent for each;
- The 50 drugs that increased the most in cost relative to the prior plan year and the change in expenditure for each drug relative to the prior plan year;
- Total plan spending on healthcare services broken down by:
    - The type of cost (including hospital costs, health care provider and clinical service cost for primary care, and health care provider and clinical service costs for specialty care);
    - Costs for prescription drugs (broken down by plan payments versus participant responsibility); and
    - Other medical costs, including wellness services.
- Average monthly premium and the associated employer/participant responsibilities; and
- Any impact on premiums or out-of-pocket costs relating to rebates, fees, etc. paid by drug manufacturers, including:
    - The amount of such payments for each therapeutic class of drugs; and
    - The amount of such payments for the 25 drugs yielding the highest such payments.

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Within 18 months of first collecting this information, HHS is required to publish a report on its website on prescription drug reimbursements under group health plans and individual health insurance coverage. This report is also required to cover prescription drug pricing trends and the role of prescription drug costs in contributing to premium increases or decreases. This information is required to be aggregated in a way to ensure that no drug or plan specific information is disclosed publicly and may not include any confidential information or trade secrets.

Much of the information required to complete these reports will likely be generated by PBMs on behalf of plan sponsors. However, it is important to keep in mind that medical claims information and premium information is also required to be included in this reporting. As a result, plan sponsors (or their representatives) will likely need to consolidate information from multiple sources to complete these filings. To that end, it is important for plan sponsors to ensure that they have a plan for ensuring the appropriate information is compiled and formatted according to any forthcoming guidance related to this reporting and timely filed.

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