OptimaHealth

Consolidated Appropriations Act:

RxDC Reporting

Frequently Asked Questions

1. **What are the Consolidated Appropriations Act rules for health plans?**

   Under the Consolidated Appropriations Act (CAA) insurance companies and employer-based health plans must annually submit information about prescription drugs and health care spending directly to the Centers for Medicare & Medicaid Services (CMS). This data submission is called the RxDC report. The Rx stands for prescription drug and the DC stands for data collection.

2. **What is the effective date for compliance of the rule?**

   The initial effective date for plans to report pharmacy and health care spending data is December 27th, 2022, for reference years 2020 and 2021.

3. **Who is affected by this new rule?**

   Most major medical commercial plans are impacted by this requirement ruling including all Optima Health fully-insured plans, and self-funded plans. FEHB plans are also in scope.

4. **What are the specific reporting requirements?**

   The CAA requires insurance companies and employer-based health plans to submit information regarding the following:

   - spending on prescription drugs and healthcare services
   - prescription drugs that account for the most spending
   - drugs that are prescribed most frequently
   - prescription drug rebates from drug manufacturers
   - premiums and cost-sharing paid by members

5. **How are the reports submitted?**

   Optima Health will compile and file the required medical reporting for plans on behalf of our fully insured and self-funded employer groups. We will file data for our individual products and our FEHB plan. The data submitted will be aggregated at the issuer and third-party administrator level rather than at the group level. The reports are segmented by the following:

   - P1, P2, P3: Plan Lists (Plan demographic details based on the Market Segment)
   - D1: Premium and Life Years (premiums paid and enrollments)
   - D2: Spending by Category (total healthcare costs by category – hospital. Primary care, prescription drugs etc.)
   - D3: Top 50 Most Frequent Brand Drugs by plan, state, and market segment
   - D4: Top 50 Most Costly Drugs by plan, state, and market segment

Consolidated Appropriations Act: RxDC Reporting

Frequently Asked Questions Continued

- D5: Top 50 Drugs by Spending Increase by plan, state, and market segment
- D6: Rx Totals, including prescriptions covered outside of the Rx benefit, by plan, state, and market segment
- D7: Rebates by Therapeutic Class by plan, state, and market segment
- D8: Rx Rebates for the Top 25 Drugs by plan, state, and market segment

6. How often are the RxDC files to be provided?

The files are required each year. The first set of files are due December 27th, 2022, for reference year 2020 and 2021. Going forward, subsequent years will be due on June 1.

7. How will Optima Health support customers affected by these reporting requirements?

There is no action required from most of our employer group plan sponsors for the initial set of reports due by December 27th, 2022.

- For employers with both Medical and Pharmacy benefits with Optima Health, we will submit the applicable Plan List (P1-P3) and Data Files (D1- D8).
- For employers with only medical coverage through Optima Health, we will submit the applicable Plan List (P1-P3) and Data Files (D1-D2). Employers should work with their third-party Pharmacy Benefit Manager to submit the (D3-D8) pharmacy files. Filing instructions and additional information on how to submit data can be found at the CMS RxDC website at: Prescription Drug Data Collection (RxDC) | CMS.
- Additional communication regarding reports to be submitted annually beginning June 1st, 2023, will be provided in January 2023.

8. Will groups receive a confirmation when reports are submitted?

CMS is not able to provide group-specific reporting information or confirmation of submission. Optima Health will send an email to employer groups and brokers in January to confirm we have submitted reports on their behalf by the December 27th, 2022 deadline. Please contact your Optima Health representative if you need information specific to your group.

9. Will Optima Health report on the data for a group that termed in the reference year?

Yes, Optima Health will report on group data only for the time the group was covered by Optima Health during the reference year.

10. How will Optima Health support customers with the D1 file premium contribution requirements?

For reporting for the 2020 and 2021 reference years due in December 2022, CMS released guidance regarding the reporting of premium information and acknowledged the difficulty in obtaining this information. According to guidance, CMS will defer enforcement of the requirement to include employer and member premium contribution amounts for 2020 and 2021 reference year reports. Optima Health will work with employers to collect data needed for the 2023 submission.

All of the information in the D1 and D2 reports that we will prepare and submit will be aggregated by issuer (Optima Health Plan or Optima Health Insurance Company) or TPA (Sentara Health Plans, Inc.) and market segment.

Consolidated Appropriations Act: RxDC Reporting

Frequently Asked Questions Continued

11. How will Optima Health calculate Premium Equivalents or other data report metrics?

For the December 2022 filing, we will calculate and submit the applicable premium equivalents for self-funded plans, using our internal data sources.

12. What approach is Optima Health using to report data?

In general, Optima Health will aggregate data by issuer or TPA and market segment. Other than the plan lists (P2), Optima Health will not report data at the group health plan level. Additional information on aggregation can be found in the CMS RxDC data collection instructions.

13. Will Optima Health be submitting reports for groups that carve out their pharmacy benefits?

No. Employers with Optima Health plans that do not include pharmacy benefits must work with their pharmacy vendor or PBM to have data submitted for D3 through D8 reports.

14. Will the reports include specialty pharmacy benefits that are covered under the medical benefit?

Yes. Pharmacy benefits that are covered under the medical benefit will be reported in the medical spending file (D2), as required.

15. What type of account or plan numbers are required to complete Plan (P1-P3) reports?

- For fully-insured small group health plans, Optima Health will include HIOS plan IDs in the plan list (P2) and EIN. HIOS numbers are not applicable to self-funded and large/midmarket fully-insured group plans. Optima Health will include EIN for large group plans.
- Health plan names and numbers we submit will be unique to the group's coverage with Optima Health, not something that would match to what another carrier for the same client would submit for the separate coverage.
- Plan sponsor names and EINs will be reported based on the information currently in our system at the time the reports are generated.

16. Will Optima Health amend contracts for self-funded groups to describe reporting support?

Group health plan sponsors will see updated language in their contracts with Optima Health. For example, the following provision will appear in most of our agreements:

"Sentara will work with Purchaser to collect and submit data required under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA) for Covered Services administered by Sentara. Purchaser agrees to provide Sentara all requested and required data needed to complete and submit the report on Purchaser's behalf."

17. How will Optima Health handle with the narrative response?

Optima Health will submit a narrative response to support the data files we are submitting on behalf of our employer group health plans.

18. Who may use the data and for what purpose?

The data is for use by the federal government to provide insight into what drives prescription drug and health care spending. The government will provide bi-annual reports based upon the data submissions in a de-identified fashion to outline trends and outliers that they have identified in pricing.

Consolidated Appropriations Act: RxDC Reporting

Frequently Asked Questions Continued

19. How do the pricing requirements for CAA RxDC Reporting compare to the Transparency in drug Coverage final rule (TiC) and other recent legislations impacting PBM?

CAA RxDC Reporting specifically differs in that data is to be reported by plans to CMS, and not made publicly available as in the final Transparency in Coverage rule. Additionally, RxDC Reporting requires aggregate cost data for a limited set of drugs. This reporting is done at a different level than TiC and requires data to be provided for each plan at the state and market segment level. By comparison, TiC requires that negotiated rates and historic net prices for a specified 90-day period be published where there was utilization provided in a machine-readable file.

20. Does CAA RxDC violate HIPAA or other security or privacy rules?

No. CAA RxDC Reporting does not alter existing privacy or security requirements. The rule does not alter or affect Optima Health's privacy or security HIPAA requirements or state or federal laws.

21. Can large self-funded groups file on their own behalf?

Self-funded groups may file their own health plan data directly with CMS in HIOS including plan lists and additional D1 through D8 files. Please notify your Optima Health representative as soon as possible if you are an employer reporting your own data.

More information on the regulations and requirements can be found on the CMS RxDC website.