COMMONWEALTH OF VIRGINIA

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MEMORANDUM

To: Pharmacy Benefits Managers; All Carriers Licensed to Write Accident and Sickness Insurance in Virginia; All Health Services Plans and Health Maintenance Organizations Licensed in Virginia; and Life and Health Interested Parties

From: Stephen Hogge, Insurance Policy Advisor, Bureau of Insurance

Date: December 31, 2020

Subject: Pharmacy Benefits Management Rebate Report Guidance and Reporting Instructions

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During its 2020 Session, the Virginia General Assembly passed Acts of Assembly Chapters 219 and 1288 (House Bill 1290 and Senate Bill 251, respectively), codified in §§ 38.2-3465 through 38.2-3470 of the Code of Virginia (Code), Among its provisions, this new law requires any carrier that contracts with one or more pharmacy benefits managers for pharmacy benefits management to submit a quarterly rebate report to the Commissioner of Insurance, either on its own or through its contract for pharmacy benefits management. This legislation took effect on October 1, 2020.

The purpose of this communication is to provide general guidance (p. 2) and line-by-line reporting instructions (p. 5) for completing the rebate report in accordance with the requirements described in § 38.2-3468 B of the Code.

Please complete the report electronically and email to BureauofInsurance@scc.virginia.gov. Include "Rebate Report" in the subject line. The initial report, covering the period October 1, 2020 through December 31, 2020, must be filed by **March 31, 2021**.

This guidance document, including the reporting instructions, and the report forms, are available on the State Corporation Commission's website at https://scc.virginia.gov/pages/Pharmacy-Benefits-Mgmt. All updates will be posted to this webpage.

Please email any questions or comments to BureauofInsurance@scc.virginia.gov or call (804) 371-9741.

General Guidance

1. Who must submit the pharmacy benefits management rebate report?

Any carrier that contracts for pharmacy benefits management with one or more pharmacy benefits managers that are required to be licensed pursuant to § 38.2-3466 A of the Code is required to submit the rebate report to the Commissioner of Insurance. The carrier may submit the report on its own or through its pharmacy benefits manager or managers pursuant to its contract for pharmacy benefits management.

2. Which entities are considered "carriers" for purposes of the reporting requirement?

A "carrier" is defined in § 38.2-3465 of the Code as having the same meaning ascribed to it in §38.2-3407.15 A and, therefore, includes:

1) any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis;

2) any corporation providing individual or group accident and sickness subscription contracts;

3) any health maintenance organization providing health care plans for health care services;

4) any corporation offering prepaid dental or optometric services plans; or

5) any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation.

A "carrier" also includes "any person required to be licensed under Title 38.2 of the Code which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title. However, a "carrier" does not include a nonprofit health maintenance organization that operates as a group model whose internal pharmacy operation exclusively serves the members or patients of the nonprofit health maintenance organization."

3. Is an employer that offers a self-funded health plan under ERISA or a government or church employer that offers a self-funded non-ERISA health plan considered a "carrier" for purposes of the rebate reporting requirement?

No. An employer sponsor of a self-funded health plan under ERISA (i.e., the federal Employee Retirement and Income Security Act of 1974) is not considered a "carrier" for purposes of the rebate reporting requirement. Likewise, a government or church employer offering a non-ERISA self-funded health plan is not considered a "carrier" for this purpose. Therefore, these entities are not required to file a rebate report. In addition, any pharmacy benefits manager with whom they have a contractual relationship for the performance of pharmacy benefits management services is not subject to the reporting requirement, though they remain subject to it for any carriers for

which they provide such services. For example, if a pharmacy benefits manager is under contract to provide pharmacy benefit management services to one or more carriers and also provides services for Medicare and Medicaid, and/or administrative services for a self-funded ERISA or government-sponsored health plan, the pharmacy benefits manager should only report the carrier data – they should not report rebates for anything other than the commercially insured plan.

4. What is a "pharmacy benefits manager"?

As defined in § 38.2-3465 of the Code, a “pharmacy benefits manager” means “an entity that performs pharmacy benefits management.” It includes “an entity acting for a pharmacy benefits manager in a contractual relationship in the performance of pharmacy benefits management for a carrier, nonprofit hospital, or third-party payor under a health program administered by the Commonwealth.”

5. Which rebates must be reported?

For purposes of this report, a “rebate” is defined in § 38.2-3465 of the Code to mean “a discount or other price concession, including without limitation or incentives, disbursements, and reasonable estimates of a volume-based discount, a payment that is (i) based on utilization of a prescription drug and (ii) paid by a manufacturer or third administrative organization, or pharmacy after a claim has been processed and paid at a pharmacy.” These are the only rebates that must be reported.

If a pharmacy benefits manager is under contract to provide pharmacy benefit management services to one or more carriers and also provides services for Medicare and Medicaid, and/or administrative services for a self-funded ERISA or government-sponsored health plan, the pharmacy benefits manager should only report the carrier data – they should not report rebates for anything other than the commercially insured plan.

6. What information concerning rebates must be reported?

For each health benefit plan, the report must include the aggregate amount of rebates:

- received by the pharmacy benefits manager;
- distributed to the appropriate health benefit plan; and
- passed on (distributed) to the enrollees of each health benefit plan at the point of sale that reduced the enrollees' applicable deductible, copayment, coinsurance, or other cost-sharing amount.

7. On what basis is the rebate information required?

The rebate information must be aggregated for each health benefit plan. It should not be provided on an individual policy basis. As defined in § 38.2-3465 of the Code, a “health benefit plan" has “the same meaning ascribed to it in § 38.2-3438.” As such, it means “a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. “Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.”

8. Should the rebate amounts be reported on a paid or incurred basis?

The rebate amounts reported should be the amounts paid during the particular reporting period and not the amounts incurred during that reporting period.

9. When must the initial rebate report be filed with the Commissioner of Insurance and how often must it be filed thereafter?

Reports must be filed quarterly. There is a one quarter look-back period. The initial report – covering the period October 1, 2020 through December 31, 2020 – must be submitted to the Commissioner by March 31, 2021, Reports for subsequent quarters are required to be filed according to the following schedule:

Quarter	Period Covered	Report Due Date
1	January 1 through March 31	June 30
2	April 1 through June 30	September 30
3	July 1 through September 30	December 31
4	October 1 through December 31	March 31

10. Should rebates related to nonresident members covered by Virginia-based group health benefit plans be included in the information reported?

Yes. If pharmacy benefits are included for members located outside of Virginia, then the report must include the requested information specific to that plan.

11. The Excel report form includes separate tabs for carriers and pharmacy benefits managers. Does this mean that they both must submit a rebate report?

No. Since the rebate report may be submitted by either the carrier or the pharmacy benefits manager on behalf of the carrier, the Bureau of Insurance has provided two versions of the reporting form to suit whichever entity files the report. One report form, either Form VAPBM-C-2020 (filed by the reporting carrier) or Form VAPBM-PBM-2020 (filed by the reporting pharmacy benefits manager on behalf of the carrier) is required. The same data should not be included on both forms. As structured, the form is designed to accommodate a carrier that reports for more than one pharmacy benefits manager and a pharmacy benefits manager that reports for more than one carrier. Although a pharmacy benefits manager may submit the report on behalf of a carrier, the carrier is ultimately responsible for making sure a report is filed.

Reporting Instructions

In addition to the general guidance, the Bureau of Insurance has prepared line-by-line instructions for completing the rebate report forms. Please complete the report electronically and email it to the BureauofInsurance@scc.virginia.gov. The initial report, covering the period October 1, 2020 through December 31, 2020, must be filed by **March 31, 2021**.

Form VAPBM-C-2020 – Carrier's Report

If submitted by a Carrier, complete only the VAPBM-C-2020 tab.

Complete boxes 1 through 6:

- Box 1: Carrier name
- Box 2: Contact person's name
- Box 3: Contact person's phone number
- Box 4: Carrier's NAIC number
- Box 5: Contact person's email address
- Box 6: Quarter and year (MUST BE IN THE FORMAT YYYY-QQ – for example, 2020-04 would be 4th quarter of 2020)

FAILURE TO COMPLETE ALL SIX BOXES WILL BE CONSIDERED EVIDENCE OF FAILURE TO FILE A COMPLETED REPORT.

Starting in ROW 12, complete ALL columns as follows:

- Column B – Insert the Health Plan name, as filed with the Bureau of Insurance – report one row for each different Health Plan
- Column C – Insert the name of the Pharmacy Benefits Manager (PBM) to whom the rebates have been paid DURING THE REPORTING PERIOD (if a Health Plan uses more than one PBM, then the rebate information specific to each PBM must be entered on separate rows)
- Column D – Insert the Virginia PBM license number
- Column E – Will be auto populated from the contents of Box 4 (if auto population fails, then manually key the NAIC number)
- Column G – Report the aggregate amount of paid rebates received by the PBM DURING THE REPORTING PERIOD
- Column H – Report the aggregate amount of paid rebates distributed to the Health Plan DURING THE REPORTING PERIOD
- Column I – Report the aggregate amount of paid rebates passed on (distributed) by the PBM to Plan Enrollees DURING THE REPORTING PERIOD
- Column J – Will be auto populated from the contents of Box 6 (if auto population fails, then manually key the Quarter and Year in the format YYYY-QQ – for example, 2020-04 would be 4th quarter of 2020)

FAILURE TO POPULATE EVERY COLUMN WITH INPUT, WHETHER ZERO OR OTHER, WILL BE CONSIDERED EVIDENCE OF FAILURE TO FILE A COMPLETED REPORT.

EXCEPT FOR ADDING ROWS AT THE BOTTOM OF THE FORM TO ACCOMMODATE REPORTING DETAIL FOR MORE THAN 29 HEALTH PLANS, DO NOT CHANGE THE LOCATION OR POSITIONING OF ANY CELLS IN THE REPORTING SHEET.

Form VAPBM-PBM-2020 – PBM's Report (Submitted on Behalf of Carriers)

If submitted by a PBM, complete only the VAPBM-PBM-2020 tab.

Complete boxes 1 through 6:

- Box 1: PBM Name
- Box 2: Contact person's name
- Box 3: Contact person's phone number
- Box 4: PBM's Virginia license number
- Box 5: Contact person's email address
- Box 6: Quarter and year (MUST BE IN THE FORMAT YYYY-QQ – for example, 2020-04 would be 4th quarter of 2020)

FAILURE TO COMPLETE ALL SIX BOXES WILL BE CONSIDERED EVIDENCE OF FAILURE TO FILE A COMPLETED REPORT.

Starting in ROW 12, complete ALL columns as follows:

- Column B – Insert the Carrier name for whom the rebate information is reported,
- Column C – Insert the Carrier NAIC number as filed with the Bureau of Insurance – a separate row should be completed for each Carrier (If the PBM is reporting on more than one Health Plan for a Carrier, then the PBM must enter the rebate information specific to each Health Plan on separate rows)
- Column D – Insert the name of the Health Plan for which the rebates are being reported
- Column E – Will be auto populated from the contents of Box 4 (if auto population fails, then manually key the PBM Virginia license number)
- Column G – Report the aggregate amount of paid rebates received by the PBM DURING THE REPORTING PERIOD
- Column H – Report the aggregate amount of paid rebates distributed to the Health Plan DURING THE REPORTING PERIOD
- Column I – Report the aggregate amount of paid rebates passed on (distributed) to Plan Enrollees DURING THE REPORTING PERIOD
- Column J – Will be auto populated from the contents of Box 6 (if auto population fails, manually key the Quarter and Year in the format YYYY-QQ – for example, 2020-04 would be 4th quarter of 2020)

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