Rebate Reporting General Guidance
(Updated January 21, 2025)

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

Any carrier that issues health benefit plans in Virginia and in connection with those plans 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 of Virginia (Code), must submit the rebate report to the Bureau.

Please note:

- *The carrier may submit the report on its own or* through its contract for pharmacy benefits*.*
- *Although a pharmacy benefits manager may submit the report on behalf of a carrier, it is the carrier's responsibility to make sure the report is filed.*

Although licensed in Virginia to write health benefit plans as defined in the pharmacy benefits management law, a carrier that does not write any such business in Virginia is not required to submit a rebate report.

2. For carriers required to submit a rebate report, must 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.

3. Must a rebate report be filed if a carrier has not received any rebates during the annual reporting period?

If the carrier is subject to the rebate reporting requirement, then it (or its pharmacy benefits manager pursuant to contract) must file a rebate report even if zero.

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

No. The report must be submitted by either the carrier or the pharmacy benefits manager on behalf of the carrier and does not need to be submitted by both for the same business.

The Bureau has provided two versions of the reporting form. Form VAPBM-C is used for filing by the reporting carrier. Form VAPBM-PBM is used for filing by the reporting PBM on behalf of the carrier. The same data should not be included on both forms. The forms are 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.

5. 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 is not considered a "carrier" for this purpose.
- No. A government or church employer offering a non-ERISA self-funded health plan is not considered a "carrier" for this purpose.

Therefore, these employer sponsors and any pharmacy benefits managers with which they have a contractual relationship for the performance of pharmacy benefits management are not subject to the rebate reporting requirement in connection with these plans.

6. Which "rebates" must be reported?

Reporting is required only for a "rebate" as defined in § 38.2-3465 of the Code.

7. What rebate information must be reported?

Prior to the statutory changes to § 38.2-3468 B of the Code that took effect on July 1, 2024, carriers, on their own or through their contract for pharmacy benefits, were required to report the following information to the Commissioner for each health benefit plan, annually on or before March 31, for the preceding calendar year:

1. The aggregate amount of rebates received by the pharmacy benefits manager;

2. The aggregate amount of rebates distributed to the appropriate health benefit plan; and

3. The aggregate amount of rebates passed on 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.

As of July 1, 2024, carriers subject to the rebate reporting requirement must now include the following additional information beginning with the rebate report to be filed for Calendar Year 2024 on or before March 31, 2025:

4. The aggregate amount of the pharmacy benefits manager's retained rebates;

5. The pharmacy benefits manager's aggregate retained rebate percentage; and

6. The aggregate amount of administrative fees received by the pharmacy benefits manager.

8. On what basis must the rebate information be reported?

The rebate information must be aggregated for each health benefit plan. It should not be provided on an individual policy basis. Refer to § 38.2-3465 and § 38.2-3438 of the Code for the definition of a "health benefit plan." "Health benefit plan" does not include the "excepted benefits" as defined

in § 38.2-3431. See the form instructions for the correct way to report information by health benefit plan.

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

The rebate amounts reported should be the amounts **paid** during the reporting period.

10. When must the rebate report be filed with the Bureau and how often must it be filed thereafter?

Carriers (either on their own or through their contract for pharmacy benefits) must file their rebate report with the Bureau each year on or before March 31 for the preceding calendar year.

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