§ 149.740 Required information.

(a) *Information for each plan or coverage.* The report required under § 149.720 must include the following information for each plan or coverage, at the plan or coverage level:

(1) The identifying information for plans, issuers, plan sponsors, and any other reporting entities.

(2) The beginning and end dates of the plan year that ended on or before the last day of the reference year.

(3) The number of participants, beneficiaries, and enrollees, as applicable, covered on the last day of the reference year.

(4) Each State in which the plan or coverage is offered.

(b) *Information for each state and market segment.* The report required under § 149.720 must include the following information with respect to plans or coverage for each State and market segment for the reference year, unless otherwise specified:

(1) The 50 brand prescription drugs most frequently dispensed by pharmacies, and for each such drug, the data elements listed in paragraph (b)(5) of this section. The most frequently dispensed drugs must be determined according to total number of paid claims for prescriptions filled during the reference year for each drug.

(2) The 50 most costly prescription drugs and for each such drug, the data elements listed in paragraph (b)(5) of this section. The most costly drugs must be determined according to total annual spending on each drug.

(3) The 50 prescription drugs with the greatest increase in expenditures between the year immediately preceding the reference year and the reference year, and for each such drug: The data elements listed in paragraph (b)(5) of this section for the year immediately preceding the reference year, and the data elements listed in paragraph (b)(5) of this section for the reference year. The drugs with the greatest increase in expenditures must be determined based on the increase in total annual spending from the year immediately preceding the reference year to the reference year. A drug must be approved for marketing or issued an Emergency Use Authorization by the Food and Drug Administration for the entirety of the year immediately preceding the reference year and for the entirety of the reference year to be included in the data submission as one of the drugs with the greatest increase in expenditures.

(4) Total annual spending on health care services by the plan or coverage and by participants, beneficiaries, and enrollees, as applicable, broken down by the type of costs, including—

(i) Hospital costs;

(ii) Health care provider and clinical service costs, for primary care and specialty care separately;

(iii) Costs for prescription drugs, separately for drugs covered by the plan's or issuer's pharmacy benefit and drugs covered by the plan's or issuer's hospital or medical benefit; and

(iv) Other medical costs, including wellness services.

(5) Prescription drug spending and utilization, including—

(i) Total annual spending by the plan or coverage;

(ii) Total annual spending by the participants, beneficiaries, and enrollees, as applicable, enrolled in the plan or coverage, as applicable;

(iii) The number of participants, beneficiaries, and enrollees, as applicable, with a paid prescription drug claim;

(iv) Total dosage units dispensed; and

(v) The number of paid claims.

(6) Premium amounts, including—

(i) Average monthly premium amount paid by employers and other plan sponsors on behalf of participants, beneficiaries, and enrollees, as applicable;

(ii) Average monthly premium amount paid by participants, beneficiaries, and enrollees, as applicable; and

(iii) Total annual premium amount and the total number of life-years.

(7) Prescription drug rebates, fees, and other remuneration, including—

(i) Total prescription drug rebates, fees, and other remuneration, and the difference between total amounts that the plan or issuer pays the entity providing pharmacy benefit management services to the plan or issuer and total amounts that such entity pays to pharmacies.

(ii) Prescription drug rebates, fees, and other remuneration, excluding bona fide service fees, broken down by the amounts passed through to the plan or issuer, the amounts passed through to participants, beneficiaries, and enrollees, as applicable, and the amounts retained by the entity providing pharmacy benefit management services to the plan or issuer; and the data elements listed in paragraph (b)(5) of this section—

(A) For each therapeutic class; and

(B) For each of the 25 prescription drugs with the greatest amount of total prescription drug rebates and other price concessions for the reference year.

(8) The method used to allocate prescription drug rebates, fees, and other remuneration, if applicable.

(9) The impact of prescription drug rebates, fees, and other remuneration on premium and cost sharing amounts.

(c) *Applicability date*. The provisions of this section are applicable beginning December 27, 2021.