COMPLIANCE ALERT

EMPLOYEE BENEFITS | APRIL 10, 2023

Agencies Release Revised Instructions for 2022 Reference Year RxDC Reporting

On March 3, 2023, federal agencies released revised Prescription Drug Data Collection (RxDC) Reporting Instructions applicable to the 2022 reference year. RxDC reporting for the 2022 reference year is due on or before June 1, 2023.

Background

The Consolidated Appropriations Act, 2021 ("CAA, 2021") includes a provision that requires group health plans and health insurance issuers (collectively "plans and issuers") to report certain specified data related to prescription drug and other health care spending, including, but not limited to: (1) general information regarding the plan or coverage; (2) the 50 most frequently dispensed brand prescription drugs; (3) the 50 most costly prescription drugs by total annual spending; (4) the 50 prescription drugs with the greatest increase in plan expenditures over the preceding plan year; (5) total spending by the plan or coverage broken down by the type of costs; (6) the average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers; and (7) the impact of premiums on rebates, fees, and other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

While the deadline for reporting 2020 and 2021 reference years was extended to January 31, 2023, the deadline for reference year 2022 reporting is June 1, 2023.

2022 Reference Year Reporting Changes

In anticipation of the June 1, 2023 deadline for reference year 2022 reporting, the agencies took into consideration some of the complexities from the 2020-2021 reference year reporting and made some changes to the filing requirements. These changes are summarized below:

- Multiple vendors may now submit the same data file on behalf of the same plan, issuer, or carrier. For example, a plan's medical benefit issuer could submit the same file as the plan's behavioral health benefit issuer, though each entity would need indicate to which data the file relates (ex. medical or behavioral health benefits).
- While discouraged, reporting entities that must create multiple HIOS submissions in the same reference year will be able to do so if the content is mutually exclusive, meaning each plan in the plan lists and data files will only be included in one submission. Multiple submissions with overlapping content are not permitted, and the reporting entity would be required to edit and delete the submissions.

- A new column has been added to the plan list P2 to collect information about, and briefly describe, benefit carve-outs (i.e., benefits administered, offered, or insured by an entity that is different than the entity that administers, offers, or insures the majority of the plan's other benefits) when multiple reporting entities are reporting on information about the same plan (this column replaces the previous column for the Plan ID). This column is optional for reference year 2022.
- Plan list instructions have been rearranged to separately address P1, P2, and P3.
- For clarity purposes only, certain columns are renamed, specifically:
    - Columns A and B in the data files (D1 – D8) are renamed from "Issuer or TPA Name" and "Issuer or TPA EIN" to "Company Name" and "Company EIN" so that it is clear that data at the plan sponsor, carrier, reporting entity, or other company level can be aggregated at this level, rather than only the issuer or TPA level.
    - Column C in the data files (D1 – D8) is renamed "Aggregation State" (rather than "State") to more clearly differentiate from the column labeled "States in which the plan is offered" in plan lists P2 and P3.
    - Column J in D1 is renamed as "Admin Fees Paid" (rather than "ASO/TPA Fees Paid") to reflect that self-funded plans pay administrative fees to other types of companies, such as PBMs.
- As with reporting for prior reference years, due to the difficulties of having multiple reporting entities for a plan in certain instances, reporting entities may aggregate, within a state and market segment, at a less granular level than the reporting entity that submitted D2. For example, within a state and market segment, a PBM submitting D3 – D8 may aggregate to the issuer or TPA level even if an entity submitting D2 aggregates at the plan sponsor level.
- For purposes of determining premium equivalents in D1, the instructions clarify the following, among others, should be subtracted from the premium equivalent:
    - Prescription drug rebates, regardless of whether the rebate received in the reference year is retrospective or prospective.
    - Stop-loss reimbursements (Note, however, that the stop loss premium paid by the plan to the stop loss carrier should be included).
- For purposes of determining and reporting total spending in D2, the instructions clarify that stop loss reimbursements, among others, should NOT be subtracted from total spending; however, prescription drug rebates expected but not yet received should be subtracted (for prescription drugs covered either under a medical or pharmacy benefit).

Additionally, the new guidance clarifies that RxDC reporting does not apply to retiree-only plans; however, it does apply for plans located in U.S. Territories (in addition to all 50 states and D.C.). **Note for self-funded plans:** When calculating premium equivalents, a self-funded plan may use the same types of costs that are used to develop COBRA premiums; however, it should report the total dollar amount actually paid for the reference year, rather than the amounts used to set the COBRA rate.

Conclusion

In our experience, carriers, TPAs, PBMs and other vendors have varying requirements and expectations of what they need from plan sponsors to successfully complete the reporting, and some may even be delegating some of the reporting responsibility to the plan sponsor. For example, if your insurance company, TPA, or PBM sent you a survey or questionnaire to collect information about plan numbers, premium, or funding types, it is likely that they are reporting the P2 and D1 files on your behalf. Therefore, it is important to respond to any requests for information you may receive from the carrier, TPA, PBM, or other vendor and to coordinate with them to understand their expectations to ensure all reporting is

completed in full on behalf of the plan. If your vendor sent you a letter telling you to create a HIOS account or stating that they will not submit P2 and D1 on your behalf, that means you must submit P2 and D1 directly to CMS (or engage a third-party to submit them for you).

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