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EMPLOYEE BENEFITS

Health Care Cost Transparency

Prescription Drug Data Collection (RxDC) Reporting Update to Instructions for 2022 Reference Year Reporting Due June 1, 2023

May 2023

On March 28, 2023, the Centers for Medicare & Medicaid (CMS) updated its guidance and instructions on the No Surprises Act health plan transparency reporting for the 2022 reference year that is due on **June 1, 2023**. See the Prescription Drug Data Collection (RxDC) Reporting Instructions. The updated instructions address several questions that were previously unanswered with respect to RxDC reporting for the 2020 and 2021 reference years (reporting for these calendar years was originally due on 12/27/2022).

While the key reporting elements and entities remain relatively unchanged in the guidance, there were significant changes to some areas of the reporting instructions. Along with other material changes, the updated reporting instructions now provide further clarity for group health plans and/or their third party reporting entities with respect to the following key points:

- Reporting entities need not report RxDC information related to retiree-only health plans (Section 1.4 of the instructions). The updated instructions; however, reaffirm that individual and group health plans (on and off the Exchange), including both grandfathered and non-grandfathered employer-sponsored health plans that include active employees, student health plans and plans maintained under the FEHB for federal governmental employers, remain subject to the RxDC reporting requirements.
- Plans, issuers and carriers in all U.S. states/districts, including the District of Columbia (DC) and the U.S. Territories[1], are subject to the reporting requirements (Section 1.5).
- Reporting entities now have more flexibility to create multiple submissions for the same reference year (Section 3.5) when the data are mutually exclusive (i.e., there is no "overlapping data" in the separate submissions).
- For the 2022 reference year reporting, multiple vendors may submit the same type of data file on behalf of the health plan (Section 3.3). Examples are provided in the instructions for cases in which there is a change in vendor during the calendar year or when different vendors provide different services (such as when there are separate vendors for medical and behavioral health benefits). It also would allow the submission of multiple D1 files for the same plan (e.g., one by a TPA or carrier and one by the plan sponsor when the TPA/carrier is unwilling to submit all D1 data). However, where possible, CMS encourages aggregation of the data into one submission.

[1] *U.S. Territories include the U.S. Virgin Islands, Northern Mariana Islands, Guam, American Samoa and Puerto Rico.*

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- The suspension of data aggregation restrictions, which applied to the 2020/2021 reference year reporting, has been extended and now applies to the 2022 reference year reporting. Without the extension, under the Interim Final Rules[2], coordination between vendors reporting on behalf of the health plan or issuer would be required (Section 5.6).

- The transition relief that allowed reporting entities to omit average monthly premiums paid by members and employers in the reporting for the 2020 and 2021 reference years ***was not*** extended. That data must be included for all health plans for the 2022 reference year, and we understand that service providers have been requesting this information. The updated instructions include a useful table to assist with calculating these amounts (p. 30).

- The updated instructions include a more detailed description regarding what should be included in the Premium Equivalent data element reported in the D1 file for self-insured plans and clarify that the Premium Equivalent should reflect "amounts that best represent the total cost of providing and maintaining coverage for the reference year. Therefore, actual costs on a retrospective basis should be used instead of funding levels whenever possible" (p. 32-33).

- With respect to stop loss reimbursements, the updated instructions clarify that stop loss reimbursements under self-insured health plans should be subtracted from total spending in the D1 file (Section 6.1) but specify that stop loss reimbursements should be included in total spending in the D2 file (Section 7.1).[3]

- Prescription drug rebates should be subtracted from premium equivalents in the D1 file (Section 6.1) regardless of whether the rebates received apply to current-year or prior-year expense. Rebates that are expected (but not yet received) should be subtracted from total spending (Sections 7.1 and 8.4 for drugs covered under a medical benefit and those under a pharmacy benefit, respectively).

- Other updates include changes to the file format to address issues relating to the different types of Plan List files (P1, P2 or P3)[4] and to the collection certain information about benefit carve-outs, the renaming of certain columns in the report and general edits for clarity.

Plan sponsors should consult with their health plan service providers (e.g., carriers, TPAs, PBMs, carve-out behavioral health vendors, etc.) to help address all required reporting elements.

[2] Under 26 CFR 54.9825-5T(b)(2)(i), 29 CFR 2590.725-3(b)(2)(i), and 45 CFR 149.730(b)(2)(i), the data submitted in files D1 and D3 – D8 must not be aggregated at a less granular level than the aggregation level used by the reporting entity that submitted the data in file D2 (Spending by Category).

[3] See RxDC Reporting Instructions for identification of cost reporting information in data elements D1-D8.

[4] P1 – individual and student market plan list, P2 – group health plan list, P3 – Federal Employee Health Benefit (FEHB) Plan. Each RxDC submission must include one of these Plan List files.

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