Published: February 12, 2024

2023 RxDC Reporting Instructions Released

Seth Bracelin | Millenium Insurance Group | (717) 354-4774 | sbracelin@millig.com

The Centers for Medicare and Medicaid Services ("CMS") recently released updated Prescription Drugs Data Collection ("RxDC") reporting instructions related to reporting 2023 data. There are some notable changes.

Background

As previously reported, plan sponsors of group health plans (typically, employers) must submit information annually about prescription drugs and health care spending ("RxDC reporting") to CMS. The first deadline was December 27, 2022 (extended to January 31, 2023) for reporting on calendar years 2020 and 2021. For reporting on calendar year 2023, the next deadline is June 1, 2024, which is a firm date even though it falls on a Saturday. It should be noted that carriers, pharmacy benefit managers ("PBMs"), and third-party administrators ("TPAs") assisting with the reporting may have earlier deadlines for employers to respond to them with certain data points (e.g., plan name, average monthly premiums).

RxDC reporting consists of uploading to CMS a total of nine spreadsheets, consisting of a plan list (P2 is used for group health plans) and eight data files (D1 through D8), plus a "narrative response." In some situations, a TPA or PBM will not handle the full filing. This often requires the employer to file at least the D1 file, and occasionally the D2 file. A P2 list file must accompany all "D" filings.

New Instructions

The following are the most notable changes for reporting for the 2023 reference year compared to the prior year:

- Changes providing clarification about what should be reported in D1:
    - Now simplified, determine the "average monthly premium" calculation by taking total annual premiums, or premium

equivalents for self-insured plans, and dividing by 12, rather than dividing by “member-months” as in prior years. The calculation is done for the “average monthly premium paid by members” and the “average monthly premium paid by employers,” respectively.

- Include under premiums or premium equivalents paid by members:
  - Member payments for COBRA coverage, including the 2% administrative fee
  - Spousal and tobacco surcharges
  - Amounts paid for coverage of an owner of an S-Corporation or Partnership if the owner works for the business and pays their premium out of personal funds
- Now optional for premium equivalents, report on a cash basis (i.e., when claims are paid) or on a retrospective basis (i.e., when claims are incurred)

- Change providing clarification about what should be reported in D2:
  - Include information for pharmaceutical supplies, medical devices, nutritional supplements, and OTCs in the appropriate spending category in D2 if the products are covered under a plan’s medical benefit

- Change related to the P2 list:
  - Provide specific language in Column C as to the specific type of carve-out benefit being reported, which is mandatory for the 2023 reference year:
    - Pharmacy only
    - Medical only
    - Behavioral health only
    - Fertility only
    - Specialty drugs only
    - Hospital only
    - Other

- Other changes generally clarifying or otherwise impacting mainly issuers, TPAs or PBMs:
    - Exclude medical devices, nutritional supplements, and over the counter (OTC) drugs from prescription drug lists (D3, D4, D5, D7, D8) unless the NDC for the product is on the CMS Drug and Therapeutic Class Crosswalk
    - Follow instructions on how to submit data when plan list or data files exceed the maximum allowable size limit in HIOS – should be quite rare at the employer level
    - Follow aggregation restrictions, which will be enforced starting with the 2023 reference year
        - Data can generally be submitted on an aggregated basis – generally by state and by market segment, then at the reporting entity level, which will generally be the:
            - Employer level,
            - Issuer level, or
            - TPA level
        - This is generally dictated by what is submitted on a D2 file, and employer level reporting is considered the most "granular"
        - The level of aggregation applied on the D2 must be applied at the same, or more granular, level to the data in D1 and D3 to D8 – examples:
            - Data submitted in D2 is aggregated according to the employer EIN, the data in D1 and D3 to D8 must also be aggregated according to the employer EIN
            - Data submitted in D2 is aggregated according to the TPA EIN, then the reporting entities for D1 and D3 to D8 may choose to aggregate at the TPA level or to aggregate according to the plan sponsor EIN. The reporting entities for D1, D3, D4, D5, D6, D7, and D8 do not have to make the same decision. For example, if D2 is at the TPA level, the reporting entity for D1 could aggregate at the plan sponsor level and the reporting entity for D4 could aggregate at the TPA level
        - Ideally for self-insured plans, D2 data will be submitted by the TPA, which will dictate the aggregation levels for D3 to D8 data. An employer will still be able to submit D1 data at the employer level

HIOS Guidance

All Covered Entities, which include agents, producers and brokers, should review the Amendment and evaluate their obligations under all applicable laws. In the event a Covered Entity determines a cybersecurity incident has occurred at

the Covered Entity, its affiliate, or at a third-party service provider, such as an insurance carrier, third-party administrator or other vendor, or is notified of same, the Covered Entity must report same to DFS within 72 hours. Each Covered Entity must provide a certification of material compliance or acknowledgment of noncompliance to DFS before April 15, 2024.

Employer Action

With respect to these new instructions, employers should:

- Identify which of the above changes will impact their filing this year.
- Work with carrier partners, TPAs, PBMs and other vendors, as appropriate, to submit the requisite 2023 data.

The instructions themselves are very helpful and answer questions about the filing requirement and provide relevant examples when appropriate.

Additional guidance and/or relief could be issued before the June 1, 2024, filing deadline. We will continue to monitor and inform you of any applicable changes.