COMPLIANCE ALERT

Prescription Data Collection Reporting Is Coming Soon

EPIC Insurance Brokers & Consultants

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Quick Facts

- Starting in 2022, employer-sponsored health plans must submit prescription drug and healthcare spending information to the Departments annually.
- Reporting for 2020 and 2021 is due December 27, 2022.
- Plan sponsors may rely on a third-party reporting entity to submit information on their behalf.
- Plan sponsors should take steps to ensure that reporting entities are fulfilling their obligations to report.

Background

As part of the Consolidated Appropriations Act of 2021 (CAA), employer-sponsored health plans, carriers, third party administrators (TPAs) and pharmacy benefit managers (PBMs) will be required to submit certain information about prescription drug and healthcare spending to the Centers for Medicare and Medicaid Services (CMS) annually. The Department of Labor (DOL) the Department of Health and Human Services (HHS) and the Treasury Department (collectively, the Departments) intend to use this information to issue public reports on prescription drug pricing costs and trends beginning in 2023. In November 2021, the Departments issued a **press release** and **interim final rules** (IFR). On June 29, 2022, CMS released updated reporting instructions for this new requirement. You can find our previous insights article on the IFR **here**.

The CAA originally required plans and carriers to submit the required information for the first time by December 27, 2021, and then by June 1 of each year thereafter; however, In August 2021, the Departments **delayed enforcement** to December 27, 2022 for reports on 2020 and 2021 data. Subsequent reports will be due June 1.

Reporting Requirements

The IFR requires employer-sponsored health plans and carriers to annually submit certain information on prescription drug and other healthcare spending to the Departments. The instructions break down the required information into two categories, Plan Lists (P) and Data Lists (D).

- P1. Individual and Student Market plan list
- P2. Group Health plan list
- P3. Federal Employee Health Benefit (FEHB) plan list
- D1. Premium and Life-Years
- D2. Spending by Category
- D3. Top 50 Most Frequent Brand Drugs
- D4. Top 50 Most Costly Drugs
- D5. Top 50 Drugs by Spending Increase

- D6. Rx Totals
- D7. Rx Rebates by Therapeutic Class
- D8. Rx Rebates for the Top 25 Drugs

A narrative response is required. Such as, describing the impact of prescription drug rebates on premium and cost sharing in the narrative response.

Plan Files

The plan lists identify the plans in a submission, collect plan information such as the beginning and end dates of the plan year, the number of members and the states in which the plan or coverage is offered. P1 is required for plans in the individual or student market. P2 is required for employer-based health plans that are not FEHB plans. P3 is required for FEHB plans.

Data Files

The data files collect premium and spending information at an aggregated state or market level, or separately for each plan. It is likely that PBMs will submit this information on an aggregate level rather than individually. The IFR recognizes that it is possible that no single entity will have all of the information necessary, so some coordination will need to occur between stakeholders such as the employer sponsor of a plan and their carrier or administrator.

TPAs or PBMs reporting on behalf of self-funded plans can, within each state and market segment, combine the data for all self-funded plans on whose behalf it is reporting. A self-funded plan is not required to have a TPA or PBM report on its behalf but are encouraged to do so. Plan sponsors should receive assurance from their TPA and/or PBM that they will be reporting on their behalf.

Submission Process

HIOS System

Data should be submitted through the Prescription Data Collection (RxDC) module on the Health Insurance Oversight System (HIOS) located on the **CMS Enterprise Portal**. Employers do not need to create a HIOS account if a third party is reporting on their behalf.

Reporting Entities

Plans can contract with issuers, TPAs, PBMs or other third-party vendors to submit data on their behalf. The entity that submits some or all required information is called a reporting entity. Multiple vendors can be reporting entities and submit data on a plan's behalf, but the instructions are clear that multiple entities should not be reporting the same data as the HIOS system cannot identify duplicate information. The RxDC instructions provide this example:

"A self-funded group health plan may contract with a TPA to submit the Spending by Category data file (D2) and separately contract with a PBM to submit the Top 50 Most Costly Drugs file (D4). The submission for a plan, issue or carrier is considered complete if CMS receives all required files, regardless of who submits the files."

Each reporting entity may only view the files that it uploads to preserve confidentiality.

Confirmation

There is currently no confirmation process in place on the CMS portal to confirm data submission. Plan sponsors are encouraged to confirm submission directly with their reporting entity.

Employer Obligations and Next Steps

The reporting responsibility lies with the group health plan sponsor, but the carriers, TPAs and PBMs will have most of the information necessary to submit the required data on behalf of employer-sponsored plans. There are some data elements that these organizations may not currently have in their systems, which may require some coordination with employers to collect the necessary information. Plan sponsors should be aware of what information reporting entities will submit on their behalf and whether they need multiple reporting entities to complete the submission. Plan sponsors should confirm in advance of the due date that the data was submitted.

Fully insured plans should be able to rely on the carrier to submit all required data to satisfy the requirement. Fully insured plan sponsors should obtain in writing the responsibility of the carrier to report.

Self-insured plans should contact their TPAs and PBMs to determine what assistance these vendors will provide and review any service agreement provisions regarding reporting responsibility, liability in the case of errors or failure to report and any additional fees incurred for the additional responsibility.

EPIC is monitoring any developments with this new requirement and will release additional resources as more information becomes available.

EPIC Employee Benefits Compliance Services

For further information on this or any other topics, please contact your EPIC benefits consulting team.