HHS Releases Revised Instructions for Upcoming Prescription Drug and Health Care Spending Reports

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The Department of Health and Human Services (HHS) has released revised instructions for group health plans to report prescription drug and health care spending data, as required by the Consolidated Appropriations Act, 2021 (CAA). This data submission is called the RxDC report. The Rx stands for prescription drug and the DC stands for data collection. In addition to prescription drug information, the RxDC report also collects information about spending on health care services and premiums paid by members and employers.

As background, the CAA generally requires group health plans to provide the RxDC report including prescription drug and healthcare spending, premiums, and enrollment information to HHS, the Department of Labor, and the Internal Revenue Service. The RxDC report is intended to aid these federal agencies in monitoring prescription drug and healthcare spending trends for possible regulatory approaches to control costs and for a biannual, publicly available report. The ongoing deadline for the annual report is June 1 for the "reference year," which is the calendar year immediately preceding the calendar year in which the RxDC is due. Accordingly, the deadline for submitting 2022 calendar year data is June 1, 2023. Reporting for 2020 and 2021 should have been submitted by December 27, 2022, under a non-enforcement policy regarding the regular June 1 deadline issued by the federal agencies.

HHS previously released data submission instructions for the 2020 and 2021 reference years to explain how the data is to be submitted through the RxDC module in the Health Insurance Oversight System (HIOS). On March 3, 2023, revised instructions were issued for reporting due on June 3, 2023. Some of the most significant changes to the RxDC reporting instructions for 2023 are:

- Specified that RxDC reporting requirements do not apply to retiree-only plans (Section 1.4). Note that account-based plans such as health reimbursement arrangements (HRAs) and excepted benefit plans (for example, limited-scope dental and vision plans, hospital or other fixed indemnity insurance, and disease-specific insurance) are also not subject to reporting.

- Allows for multiple vendors to submit data on behalf of the same group health plan (Section 3.3) and for a reporting entity to create multiple submissions in HIOS for the same reference year (Section 3.5).
- Specified that prescription drug rebates should be subtracted from premium equivalents in D1 regardless of whether the rebate received in the reference year is retrospective or prospective (Section 6.1.)
- Specified that stop-loss reimbursements should be subtracted from premium equivalents in D1 (Section 6.1), but not subtracted from total spending in D2 (Section 7.1).
- Specified that rebates expected, but not yet received, should be subtracted from total spending (Section 7.1 for drugs covered under a medical benefit and Section 8.4 for drugs covered under a pharmacy benefit).

Although the reporting requirement is imposed on the group health plan, plan sponsors will certainly want to contract with the insurance carrier for fully insured plans and third-party entities such as their administrator for self-insured plans to provide the reporting on their behalf. Transferring the responsibility to an insurance carrier shifts the liability to the insurance carrier, but plan sponsors of self-insured plans remain liable for reporting assumed by a third-party entity.