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Here We Go Again: Prescription Drug Reporting Due by June 1st

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"Didn't we just do this?" might be the first question asked by many health plan sponsors and administrators when gearing up to complete 2022 prescription drug reporting by June 1, 2023. The answer to that question is both "yes" and "no." Yes, because group health plans were required to complete prescription drug reporting for the 2020 and 2021 reference years by January 31, 2023. No, because the agencies released revised instructions for reporting 2022 year data—meaning the reporting exercise for 2022 may be a little different than the last go-around.

By way of reminder, the Consolidated Appropriations Act, 2021 requires that group health plans and issuers report, on an annual basis, certain prescription drug and health care spending information to the DOL, HHS, and Treasury. The reporting is done in coordination with the plan's service providers and is uploaded to a dedicated Centers for Medicare and Medicaid Services website. While the core reporting elements remain the same from last year, there are changes for reporting 2022 data of which plan sponsors and administrators should be aware, some of which are summarized below:

- **No General Good Faith Efforts Relief**: For 2020 and 2021 reporting, the agencies confirmed in FAQs Part 56 that they would not take enforcement action against health plans or issuers that utilized good faith efforts and a reasonable interpretation of the regulations to complete their required reporting. To date, the agencies have not announced similar relief for 2022 reporting. Additionally, the limited exception for plans to report certain information for 2020 and 2021 via email (rather than uploading the information to the CMS website) does not apply for 2022 reporting.

- **No Nonenforcement Relief for Reporting Average Monthly Premium Paid by Employers Compared to Members**: Plans are required to report the average monthly premium paid by employers compared to members. The prior instructions offered nonenforcement relief for 2020 and 2021 with respect to this data element, noting that some reporting entities could have difficulty in obtaining this information. The instructions for 2022 reporting do not offer similar nonenforcement relief, meaning that reporting entities that relied on this

nonenforcement relief for 2020 and 2021 reporting will need to make a new action plan to address 2022 reporting.

- **Self-Funded Plans Cannot Rely on COBRA Rate to Determine Total Plan Cost**: Self-funded plans are required to report the total cost of providing and maintaining coverage for the reference year. For 2020 and 2021 reporting, the instructions stated that plans could use the same costs taken into account for purposes of calculating the COBRA premium (minus any administrative charge) to determine the total plan cost. For 2022 reporting, the instructions clarify that plans cannot necessarily rely on the COBRA rate to calculate the total annual cost—instead, plans are required to calculate and report the total annual cost actually paid for the reference year, rather than the amounts used to set the COBRA rate.

- **Confirmation that Multiple Vendors Can Submit Same Data File Type for Plan**: One sticking point during the last round of reporting was coordinating multiple reporting entities to prepare a single data file on behalf of a plan. For 2022 reporting, the agencies confirmed that while plans are "encouraged" to submit only one data file of each data file type for the same plan, if vendors are unwilling or unable to work together to complete a data file for a plan, it is permissible for more than one reporting entity to submit the same data file type on behalf of the same plan.
    - ***Example – Two Separate Issuers for Same Plan***: If a plan has two separate issuers—one for behavioral health benefits and one for medical benefits—both issuers can submit a D2 file ("Spending by Category") on behalf of the plan. The first issuer would report the plan's data relating to behavioral health benefits. The second issuer would report the plan's data relating to medical benefits. jenni
    - ***Example – Change in Vendor During Year***: If a plan changes vendors (*g.*, a TPA or PBM) during the year, it is acceptable for both vendors to submit data files on behalf of the plan. The previous vendor would report the plan's data from the period prior to the change, while the current vendor could report the plan's data for the period following the change.

Takeaways for Plan Sponsors: While the revised instructions offer some welcome clarifications, plan sponsors should be aware of the changes for 2022 reporting which may require some quick pivots to ensure the plan is on track to meet its reporting obligations. In particular, plan sponsors that may have missed vendor deadlines that would permit the vendor to complete the required reporting on the plan's behalf should put together an action plan to submit the required data by June 1, 2023—as of now, there is no extension of this deadline and no relief that would excuse the plan's non-compliance.

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