# Prescription Drug and Healthcare Spending (RxDC) Reports

*Instructional Guide for Completing the CareFirst RxDC Survey*

FULLY-INSURED GROUP HEALTH PLANS

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# Introduction – What is RxDC?

Under Section 204 of the Consolidated Appropriations Act (CAA) of 2021, health insurers offering group health coverage must report data annually on prescription drugs and healthcare spending to the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury (USDT).

The Centers for Medicare & Medicaid Services (CMS) collects the Section 204 reports and has published guidance and resources on their website at https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/prescription-drug-data-collection.

The reports are commonly referred to as "RxDC" where "Rx" stands for Prescription Drug and "DC" stands for Data Collection. It is important to note that the RxDC reports also require data unrelated to prescription drugs, including premium, enrollment, and other spending related to medical costs.

The RxDC reporting consists of three different types of files – plan lists (or P files), data files (or D files), and a Narrative Response file. The P files are used as a mapping tool for CMS to reconcile the data being reported in the D files. Any entity submitting a D file, must also submit a P file identifying the plans whose data is included in the D file. The P2 is the P file applicable to group health plans.

| Subject | Plan Lists | Data Files |
|---|---|---|
| **File Names** | **P stands for Plan**<br>1. P1 Individual and student market plan list<br>2. P2 Group health plan list<br>3. P3 FEHB plan list | **D stands for Data**<br>1. D1 Premium and Life-Years<br>2. D2 Spending by Category<br>3. D3 Top 50 Most Frequent Brand Drugs<br>4. D4 Top 50 Most Costly Drugs<br>5. D5 Top 50 Drugs by Spending Increase<br>6. D6 Rx Totals<br>7. D7 Rx Rebates by Therapeutic Class<br>8. D8 Rx Rebates for the Top 25 Drugs |
| **Purpose** | The plan list identifies the plans in a submission and collects plan-level information required by statute, such as plan year effective dates. | The data files collect premium and spending information at an aggregate level. |
| **Requirement** | • P1 is required for plans in the individual or student market<br>• P2 is required for employer-based group health plans that are not FEHB plans<br>• P3 is required for FEHB plans | • D1-D8 are required for plans with medical and pharmacy benefits<br>• D1 and D2 are required for plans with only medical benefits<br>• D1 and D3 – D8 are required for plans with pharmacy benefits only |
| **Narrative Response File** | A Narrative Response applicable to each plan is required. Different reporting entities may be responsible for different parts of the Narrative Response. | |

The RxDC reporting is due by June 1st of each year for the applicable reference year data and is required to be uploaded in the Health Insurance Oversight System (HIOS). The term “reference year” refers to the previous calendar year plus a three-month runout for spending tied to that calendar year.

This allows for payments made in January through March of the current year for claims incurred in the previous calendar year to be included in the data. Any payments made after March 31st would not be included in the data, even if the associated claims were incurred in reference year.

# Getting Started – What You Need to Know

CareFirst is committed to submitting all RxDC reporting on behalf of our current and previous clients. The reporting requires certain information that CareFirst must collect each year. Below are some key points to remember.

## In General

- **Clients that do not complete the form submission by the due date set by CareFirst will be excluded from CareFirst's D1-Premium and Life Years submission.**
- Surveys can be redone as many times as necessary prior to the due date. CareFirst will use the most recent data submitted to complete the reporting.
- **Financial data should be reported as total dollar amounts for the calendar year.**
  - Do not provide percentages (%).
  - Do not provide averages.
  - Include the decimal if reporting an amount that isn't an even dollar amount.
  - CareFirst will aggregate total dollar amounts for all clients in the applicable market segment before calculating the average(s) that will be reported.
  - Any data provided that is clearly inaccurate will result in the client being excluded from CareFirst's D1-Premium and Life Years submission. For example, if the sum of Premiums Paid by Member and Premiums Paid by Employer is less than the Total Premiums Billed for 1 month but the client had active coverage for 9 months in 2024.
- If another insurer is submitting a D1 file on behalf of the client that includes the data associated with the benefits administered by CareFirst during the calendar year, the client can indicate this by choosing the "opt out" response in the survey.
- Clients that want a record of their submission should print the review screen before submitting the completed survey. No additional confirmation will be provided.

## Aggregation Restriction

In the interest of providing our current and previous clients with maximum flexibility when additional entities will be reporting on their behalf, CareFirst is submitting the RxDC reports to CMS in aggregate under the **CareFirst, Inc. (EIN 52-2069215)** entity. This includes the **D2 Spending by Category** file that regulation identifies as the benchmark for client data aggregation.

Any client data submitted by other entities can therefore be aggregated at the **Issuer, TPA, Plan Sponsor, or Group Health Plan** level and remain compliant with the aggregation restriction.

# Providing Data to CareFirst

This section provides additional detail about the information you are being asked to provide in the RxDC survey.

## States where the plan is offered *(required)*

Select the states and territories in which the plan or coverage is offered. If a plan is offered in every state and in DC, select "National". If a plan is offered nationally and in one or more territories, select "National" and the applicable territories.

**For purposes of RxDC reporting, a plan is considered "offered" in a state if a person living or working in that state would be eligible to obtain coverage under the plan from the employer.** Plans may enter "National" if a person living or working in *any* state and DC would be eligible to obtain coverage under the plan from the employer.

## TOTAL Premium Paid by Members *(required)*

Enter the total premium dollars paid by members within the calendar year for any medical and pharmacy benefits through CareFirst, including COBRA coverage (premiums and the 2% administrative fee) and any surcharges or wellness differentials assessed on the member (e.g., tobacco or spousal surcharges).

**Note:** Premiums and COBRA administrative fees paid by COBRA enrollees should be included in the Total Premium Dollars Paid by Members as indicated above. **If the employer pays a portion of COBRA premiums** (e.g., 20% in an 80/20 split), those amounts should be included in the Total Premium Dollars Paid by Employers as applicable.

## TOTAL Premium Paid by Employers *(required)*

Enter the total dollars paid the employer within the calendar year for any medical and pharmacy benefits through CareFirst, excluding the amount paid by members from above. If applicable, include any portion of COBRA premiums paid by the employer (for example, with an 80/20 split).

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## 200+ Fully Insured Clients – PBM Name & PBM EIN *(only required if applicable)*

If the client has pharmacy coverage that is **NOT** through CareFirst (known as "pharmacy carve-out"), enter the Pharmacy Benefits Manager (PBM) name and the 9-digit Employer Identification Number (EIN) without dashes (Ex: 012345678).

**Leave these fields blank if your prescription drug benefits are included through CareFirst.**

# Large Clients with Pharmacy Carve-Out

## Does Not Apply to Clients in the Small Group or Midsize Markets (2-199)

For clients that did not have pharmacy benefits included through CareFirst and CVS Caremark, CareFirst will submit the following files with the data that applies to the benefits we administered:

- **P2** Group Health Plan List
- **D1** Premium and Life Years
- **D2** Spending by Category
- **Narrative Response**

Clients will need to work with the applicable pharmacy benefits manager (PBM) for submission of the data related to the prescription drug coverage, including all of the D3-D8 files and components of the Narrative Response related to that coverage.

Clients may choose to include all relevant premium data in their survey submission to CareFirst if the PBM is not willing to also submit a D1 file on their behalf with the amounts related to the prescription drug coverage. Clients are welcome to do this without any additional communication with CareFirst required.