Prescription Drug and Healthcare Spending (RxDC) Reports

Informational Guide for the CareFirst Annual RxDC Submission

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 reporting is 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 require data unrelated to prescription drugs, including premium, enrollment, and other spending related to medical costs.

There are three different types of files included in the reporting – 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(s). The P2 is the P file applicable to group health plans.

Subject	Plan Lists	Data Files
File Names	**P stands for Plan** 1. P1 Individual and student market plan list 2. P2 Group health plan list 3. P3 FEHB plan list	**D stands for Data** 1. D1 Premium and Life-Years 2. D2 Spending by Category 3. D3 Top 50 Most Frequent Brand Drugs 4. D4 Top 50 Most Costly Drugs 5. D5 Top 50 Drugs by Spending Increase 6. D6 Rx Totals 7. D7 Rx Rebates by Therapeutic Class 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 • P2 is required for employer-based group health plans that are not FEHB plans • P3 is required for FEHB plans	• D1-D8 are required for plans with medical and pharmacy benefits • D1 and D2 are required for plans with only medical benefits • 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 must 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 the reference year.

Getting Started – What You Need to Know

CareFirst is committed to supporting our clients by submitting all RxDC reporting on their behalf. The reports require certain information that CareFirst must collect from each client every year. Below are some key points to keep in mind about this data request.

In General

- CareFirst will submit all RxDC reporting with data aggregated under CareFirst, Inc. and an EIN of 52-2069215.
- **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.**
- Forms can be resubmitted as many times as necessary prior to the due date. CareFirst will use the most recent data submission to complete the reporting.

Accessing and Completing the Annual RxDC Submission Form

- Clients can access the form by logging into the secure CareFirst Employer Portal (or Broker Portal when applicable). Clients that have not previously registered may do so by visiting carefirst.com.
- **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 entity 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 form should still be accessed and completed by selecting the "opt-out" button.
- Clients that want a record of their submission should print the screen with the completed form before clicking submit and the subsequent pop-up that indicates a successful submission. No other confirmation will be provided.

Market Segment Changes After January 1st of the Calendar Year

If the client renewed their plan benefits with CareFirst for a plan year that was effective after 1/1 of the reference year and that renewal included a market segment change, please review the "Mid-year Market Segment Changes" section of the RxDC CareFirst Portal User Manual(s).

What qualifies as a mid-year market segment change?

- Moving from the Small Group market to the 51+ market, or vice versa
- Moving from the Self-Insured market to the Fully Insured market, or vice versa

What <u>does not</u> qualify as a mid-year market segment change?

- Choosing different benefit plans (ex. BluePreferred instead of BlueChoice)
- Changing member cost-share amounts (ex. Increasing the deductible)
- Changing metal level (ACA market)
- A change to your CareFirst Group ID

Providing Data to CareFirst

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

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

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

If the client had pharmacy coverage that was **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 were included through CareFirst.

Fully Insured Group Health Plans (3/25)